

The relationship between compulsive overeating behaviour and self-harm: An analysis of YouTube videos.

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**Declaration**

This work is original and has not been submitted in relation to any other degree or qualification.

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**Date:** 22/09/17

## Research Module Meeting Log 2016/2017

**NAME:** CLAIRE C WYATT BSc

**SUPERVISOR:** DR HANNAH HEATH BSc, MSc, PhD

Date	Discussion Topics
23/11/16	Discussed independent project concept and agreed supervision relationship. CW to prepare project overview and send to HH.
30/11/16	Discussed independent project form and signed independent project brief declaration for submission.
11/1/17	Discussed first draft of ethics application form and information sheet.
25/1/17	Reviewed ethics application form and agreed changes.
22/2/17	Discussed completion of amendment form for ethics committee.
15/3/17	Discussed ethics committee approval, first 10 links sent to HH for approval, self-harm lecture. CW to prepare gantt timeline for dissertation project.
22/3/17	Discussed YouTube links and HH approval
17/5/17	Catch up following leave and assignments to discuss progress of link approval and transcription.
14/6/17	Agreed to work on sending through final links for approval to move forward with transcription and coding.
28/6/17	HH to review remaining links and send through approval. Discussed transcription formatting and CW agreed to progress with transcription and coding. Further meetings from July to September to be held by phone call due to distance unless adhoc f2f meetings required.
3/8/17	Agreed to reduce number of YouTube links to total 20 due to sourcing difficulty with self-harm videos. Agreed to provide outline plan of dissertation to HH for review and feedback. Agreed to send HH first coded transcription for review and feedback.
6/9/17	Discussed introduction and methodology review by Supervisor and additional points for inclusion/exclusion.
13/9/17	Reviewed and discussed structure of analysis and discussion.
Various	Email correspondence

SIGNED

STUDENT \_\_\_\_\_ DATE: \_\_\_\_\_

SUPERVISOR \_\_\_\_\_ DATE: \_\_\_\_\_

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\* \* \*

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\* \* \*

*Thank-you Dad, for the endless 'chats', for, being my cheerleader when times were tough, for your resolute belief in me, for always wanting the best for me and for supporting me so that all of this was even possible.*

\* \* \*

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\* \* \*

*And thank-you, to my Ma, I can't imagine how thrilled you would have been to have seen me do this. I did it Ma, can you believe it, I did it!*



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## Abstract

Self-harm behaviour and the relatively unrecognised behaviour of compulsive overeating are secretive and isolating in nature. Compulsive overeating behaviour is under-researched and frequently misaligned with Binge Eating Disorder due to a lack of understanding and knowledge. Research investigating self-harm behaviour exists, although qualitative research is limited. This study looked to address the research question, *'How do those who have compulsive overeating behaviour differ from those who self-harm?'*

The design of the study was a qualitative Thematic Analysis based on Braun and Clarke's (2006) six stages of analysis. Twenty participants' describing their personal experience of compulsive overeating and self-harm behaviour, through the platform of YouTube, were analysed, revealing 18 main themes. The findings illustrate similarity in the psychological, emotional and behavioural processes of self-harm and compulsive overeating behaviour, although several differences were identified relating to the research question. Key differences identified were the age of onset of behaviour, with existing research and the results of this study showing the prevalent onset of self-harm behaviour in adolescence whereas the results suggest compulsive overeating emerges at a much younger age. Differences were also highlighted in the participants experience and response to life events, their need to belong, in the formation of self-esteem and in the recovery process. Future research furthering intrapersonal and interpersonal understanding of compulsive overeating behaviour as a disorder may inform the design of better prevention and treatment, in addition to exploring the concept of compulsive overeating behaviour as a method of self-harm. Further qualitative research exploring the self-harm recovery process is recommended, to further develop preventative measures and treatment.

## **Introduction**

### Why compulsive overeating and self-harm?

Compulsive overeating is a complex disorder with relatively little understood or researched about its underlying causes and development (American Psychiatric Association, 2013). Compulsive overeating is not referenced as a separate disorder in either the Diagnostic and Statistics Manual version 4 (DSM-4) (American Psychiatric Association, 2000) or the current DSM-5 (American Psychiatric Association, 2013), whereas Binge Eating Disorder, a disorder that has overlapping traits with compulsive overeating behaviour is, but does not comprise specific traits of Compulsive overeating, such as compulsion or the emotional, psychological and behavioural elements of self-harm.

Past research and studies relating to eating disorders have focused predominantly on Anorexia Nervosa, Bulimia Nervosa and Binge Eating disorder and the co-morbidity with the behaviour of self-harm (Sansone & Levitt, 2002; Welch & Fairburn, 1996). Little, however, exists reviewing the possibility that the behaviour of compulsive overeating could be considered a form of self-harm behaviour (Favazza 1989; Paul et al. 2002; Sansone & Levitt 2010; Solano et al. 2004). It was therefore proposed that a study investigating the relationship between compulsive overeating and self-harm behaviour would contribute toward the understanding of how these behaviours differ.

### Epidemiology of Eating disorders

Research to date, such as Giannini, Newman and Gold (1990), Garfinkel and Modofsky (1980), Vitousek and Manke (1994) and Stice, Telch and Rizvi (2000) has sought to understand and bring attention to eating disorders, predominantly focusing on the conditions of Anorexia Nervosa (AN), a restriction of food, fear of gaining weight and dysmorphia of the body (American Psychiatric Association, 2013) and Bulimia Nervosa (BN), a behaviour of intermittent binge eating, a lack of control with eating and compensatory behaviours to avoid weight gain such as self-induced vomiting, laxative or diuretic abuse, fasting or excessive

exercise (American Psychiatric Association, 2013). Binge eating disorder (BED) is a relatively newly recognised disorder, characterised by behaviours of recurrent binge eating episodes concurrent with a lack of control, rapid consumption, emotional distress, shame and guilt (American Psychiatric Association, 2013).

It is evident in this review, that the progress of understanding, acknowledgement and acceptance of eating disorders has been problematic and protracted with the most currently recognised disorders of AN, only being officially acknowledged as a separate disorder by the DSM-3 in 1980 and BN in 1987. BED was only recognised as a separate disorder from BN in the DSM-4 (American Psychiatric Association, 2000) in 2013, less than 5 years ago (BEDA, 2016). Following this recognition, published research studying the prevalence and impact of eating disorders and specifically BED on society, has revealed that BED is three times more ubiquitous than both AN and BN combined (Hudson, Hiripi, Pope & Kessler, 2007). Evaluating mortality rates among individuals with BED however, is complex due to the significantly higher prevalence of morbid obesity associated with BED and the resulting increased risk of mortality (Smink, Hoeken & Hoek, 2012). It is suggested that as of 2013, approximately 600,000 people in the UK were experiencing an eating disorder with inpatient treatment figures increasing at an average rate of 7% a year since 2009 (BEAT, 2015). The National Institute of Health and Clinical Excellence estimates the proportion of males with an eating disorder in the UK is 11% (BEAT, 2015). A study by Micali et al. (2017) revealed 15.3% of women in mid-life (an average age of 47.78 years) met the criteria for a lifetime eating disorder with 3.6% of those experiencing an eating disorder in the last 12 months.

Despite DSM-5 (American Psychiatric Association, 2013) efforts to refine the definition of eating disorders and reduce the number of individuals in the 'Other' category, a large number of individuals experiencing eating disorders, persistently fail to identify with the confined diagnostic criterion of AN, BN or BED, leaving only the categories of 'Other specified feeding and eating disorder' (OSFED) and 'Unspecified Feeding or Eating Disorder' (UFED) as a point of reference (Hay, Giroso & Mond, 2015; Micali et al., 2015; Smink et al., 2014). This supports

the idea that there continues to be a lack of understanding about eating disorders that fall into the 'other' category, such as compulsive overeating behaviour, subsequently highlighting a necessity and credibility for further research, such as this study.

### Definition of Compulsive Overeating

Owing to the lack of acknowledgement and research supporting compulsive overeating as a separate disorder (Davis & Carter, 2009), compulsive overeating is often grouped and defined with BED (Wardle, 1987). BED is recognised as similar in diagnostic features to BN, where a person is unable to control eating large quantities of food mindlessly or in a "discrete period of time" (American Psychiatric Association, 2013).

Unlike BN however, compulsive eaters do not purge their food and therefore often have difficulty controlling or maintaining a healthy body weight.

As compulsive overeating is not currently differentiated from BED, it is referred to rather as a behaviour that describes 'eating patterns that feel out of control and which can feel like an addiction to food' (National Centre for Eating disorders, 2012). Many of the traits of compulsive overeating and binge eating behaviour overlap, such as the compulsive and repetitive behaviour of overeating despite damaging health, financial and social consequences and common feelings of remorse, distress and lack of control (Davis, 2013; Wardle, 1987). The key differences between binge eating and compulsive overeating are, binge eating is an action 'triggered' by an overwhelming emotion, event or situation, diagnostically determined to last "usually less than 2 hours" (American Psychiatric Association, 2013, p.346) whereas compulsive overeating behaviour, similar to addiction (Davis 2013; Davis & Carter 2009; Filbey, Myers & DeWitt, 2012), presents as a psychological obsession with food, body image and weight in addition to a physical compulsion to consume or 'use' food as a coping mechanism and is not confined by time or quantity parameters.

Compulsive overeating and BED are frequently erroneously classified as the same disorder (The National Centre for Eating Disorders, 2012). In Davis and Carter's (2009) study,

compulsive overeating behaviour is described as “unique” (Davis & Carter, 2009, p.6) straddling both substance and behavioural addiction, offering possible illumination to the ambiguity of the subject by opening discussion on whether compulsive overeating is a behavioural disorder or an, as yet unrecognised addiction. Filbey, Myers and DeWitt’s (2012) findings on reward circuit function in individuals with compulsive eating supports the concept of compulsive overeating as an addiction.

Several contributory factors to the aetiology of eating disorders have been identified in past research, however, this is limited due to the lack of recognition of compulsive overeating behaviour as a separate disorder. Childhood trauma and abuse has been shown to be associated with binge/purge disorders, supported by past studies (Fairburn et al., 1997; Hilbert et al., 2014) and a lack of autonomy or control has been identified as contributory to BED (Micali et al., 2017). Micali et al.’s (2017) paper suggests that life experiences and events in childhood along with interpersonal sensitivity are common underlying causes of all eating disorders.

Contrastingly, Wardle’s (1987) study, references Randolph’s (1956) concept of food allergies (Wardle, 1987) as contributory to the aetiology of compulsive eating. Randolph (1956) suggests food allergies create an intolerance to specific foods causing “paradoxical cravings and loss of control” (Wardle, 1987, p.48) like addiction and illustrated in Davis & Carter’s (2009) dependency model. Several theories and models have been proposed to explain the aetiology of overeating, from an emotional regulation viewpoint, including the ‘escape theory’, developed by Heatherton and Baumeister (1991) describing an alleviation of negative affect through binge eating; emotional arousal theory proposed in Pine’s (1985) study, describing the action of overeating as being evoked by emotional arousal and used to reduce emotional arousal and Polivy and Herman’s (1993) affect regulation theory, describing the regulation of emotions following the behaviour of binge eating.

Most research investigating overeating however, has focused on the neurobiological underpinnings of the behaviour in terms of addiction. Biological models of overeating allude



to certain foods such as sugar and fat, being analogous to addictive substances, affecting reward mechanisms in the brain with dopamine-activation and producing behavioural changes akin to those affected by chemical drugs (Johnson & Kenny, 2012). Whereas, behavioural models, perceive overeating as a behavioural phenotype of the subgroup of obesity, resembling behavioural drug addiction such as shopping, gambling etc. with reward and reinforcement through eating. (Ziauddeen, Farooqi & Fletcher, 2012).

Davis and Carter (2009) describe behavioural consequences of compulsive overeating including “pleasant taste, the increased energy from rises in blood glucose and an improved mood” (Davis & Carter, 2009, p.5) and Cassin and Von Ranson (2007) consider withdrawal symptoms from compulsive overeating behaviour including “irritability, moodiness, anxiety, restlessness, migraines, insomnia, poor concentration and lethargy” (Cassin & Von Ranson, 2007, p.689). Similarly, the consequences of compulsive overeating behaviour identified by recovery organisations include serious medical conditions such as diabetes, heart disease, hypertension, sleep apnoea, depression, kidney disease, arthritis, osteoporosis, stroke, and obesity (Eating Disorder Support, 2017), although limited to no research could be found exploring the emotional and psychological implications of this behaviour.

Despite the studies completed to date, there appears to be limited to no research available on the interpersonal and intrapersonal cause and effect of compulsive overeating behaviour, such as, interpersonal anxiety, depression, low self-worth, dieting or negative body image recognised by treatment and recovery organisations (National Centre for Eating Disorders, 2012). This gap in the research constitutes further support for the current study.

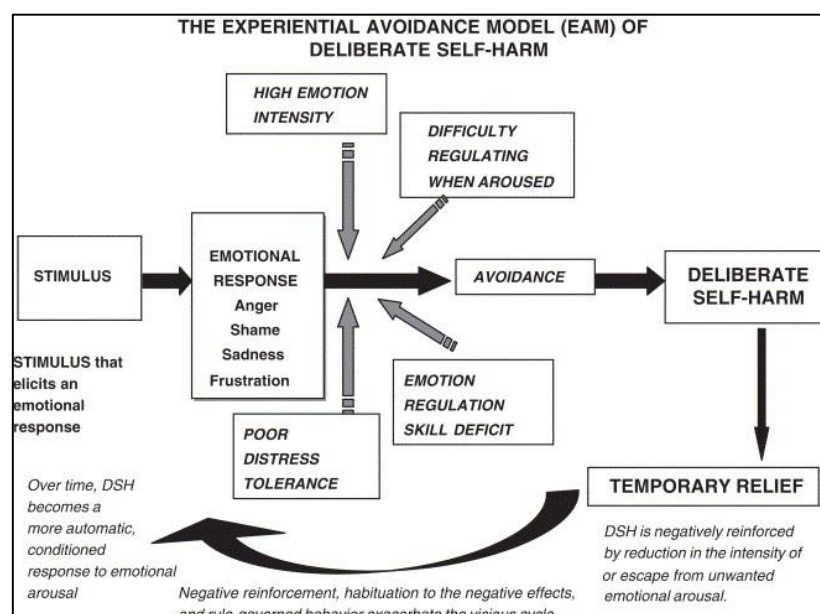
### Definition of Self-Harm

Hawton et al. (2002) define self-harming behaviour as ‘an act with a non-fatal outcome’, inflicted with wounds to self or behaviour of self-poisoning or overdose. Self-harm behaviour has a fluidity and interchangeability of methods used to self-harm as well as being repetitive in nature (Hornor, 2016). There are multiple terms used to describe self-harm behaviour, that

may be both suicidal and nonsuicidal in intent, including, deliberate self-harm, self-injury, self-mutilation, non-fatal self-harm, attempted suicide and parasuicide (Skegg, 2010, Waters & Ness, 2016).

Contrastingly, DSM-5 (American Psychiatric Association, 2013) defines self-harming behaviour as Nonsuicidal Self-Injury (NSSI) where an individual self-inflicts minor to moderate damage (nonsuicidal) to the surface of the body inducing bleeding, bruising or pain with the expectation of experiencing a sense of relief from negative affect, resolving interpersonal conflict and inducing a positive state. Additional criteria for NSSI in the DSM-5 includes, a disruption to normal functioning with episodes of behaviour lasting five or more days of the year, a preoccupation with the act outside of the individuals control and behaviour occurring outside of an altered state of mind for example whilst not intoxicated or experiencing a psychotic episode (American Psychiatric Association, 2013).

This behaviour acts as a coping mechanism to manage, by way of reducing or releasing, overwhelming emotion and interpersonal anxiety, as proposed in Chapman et al.'s (2005) Experiential avoidance model (See *Figure 1.*) and is devoid of suicidal intent (American Psychiatric Association, 2013).



*Figure 1.* Graphic depiction of the Experiential Avoidance Model (EAM) of deliberate self-harm (DSH) (Chapman et al., 2005, p. 373)

There has been considerable debate regarding the criteria and inclusion of NSSI in the DSM, separate to being a criterion of Borderline Personality Disorder (Andover, 2014) and currently NSSI is categorised under Conditions For Further Study (American Psychiatric Association, 2013). Socially accepted behaviour such as tattoos, piercings and nail biting are not considered to be forms of nonsuicidal self-harm (Hornor, 2016).

The definition of NSSI in the DSM-5 is problematic as it focuses solely on damage to the surface of the skin, affording little consideration to motivation or intent (Hawton et al., 2002; Taylor, 2003), nor is there attention given to other self-harming behaviours such as self-poisoning and overdose that are also methods of self-harm without intent of suicide (Skegg, 2010). Statistics highlight this shortcoming with self-poisoning cases accounting for 86% of self-inflicted hospital admissions (HSCIC, 2017) despite being an unrecognised self-harming behaviour (Kapur, Cooper, O'Connor & Hawton, 2013).

Self-harm behaviour comprises a wide spectrum of method, motivation, intent, severity and outcome, with research illustrating prevalence of this behaviour in the adolescent population (Hornor, 2016; Hawton, Saunders & O'Connor, 2012). Official statistics suggest that the number of admissions to UK hospitals for deliberate self-harm has dropped, from 117,719 in 2013-14 to 110,847 in 2014-15 (NHS Digital, 2016), although community led studies indicate that the number of unreported cases of self-harm, supported by a social network, are vastly greater in number (Madge et al., 2008). Hawton, Saunders and O'Connor (2012) note that self-harm behaviour at "community level" (Hawton, Saunders & O'Connor, 2012, p.2373) is consequently largely hidden from the official statistics available.

Hawton, Saunders and O'Connor (2012) state that findings from community research reveals 10% of adolescents, more commonly females, have reported experience of self-harm behaviour, although only one in eight adolescents will present to hospital. In contrast, a systematic review and meta-analysis conducted by Swannell et al. (2014) highlights significant heterogeneity of estimated prevalence of nonsuicidal self-injury in past studies and presents

revised findings of NSSI prevalence of 17.2% among adolescents and 5.5% among adults. Other studies suggest that 5-9% of adolescents report recent self-harm behaviour patterns and women aged 15-24 years and men aged 25-34 years are at the highest risk of hospital presentation (Skegg, 2010). An estimated 4% of the adult population engage in nonsuicidal self-harm behaviour according to Selby, Bender, Gordon, Nock and Joiner (2012).

Increased risk factors identified with self-harm behaviour include: adolescents, females, individuals who are socioeconomically disadvantaged, of homosexual/bisexual orientation or who might have experienced childhood trauma and interpersonal difficulty (Skegg, 2003; Skegg, 2010). There is also extensive research evidence to support the link between childhood trauma and self-harm behaviour (Klonsky, Oltmanns & Turkheimer, 2003), although studies such as Zweig, Paris and Guzder (1994) have challenged this. Self-harm behaviour is also frequently associated with experience of substance abuse, eating disorders, posttraumatic stress disorder, depression and anxiety disorders (Klonsky, Oltmanns & Turkheimer, 2003; Skegg, 2010; Wester & Trepal, 2017) as well as personality disorders, particularly borderline personality disorder (Klonsky, Oltmanns & Turkheimer, 2003).

The consequences of self-harm behaviour are both physical and psychological and are varied due to the diverse nature and spectrum of severity such as cutting, scratching, burning, hitting, picking, punching and hair pulling (Rodav et al., 2014; Wester & Trepal, 2017). Self-harm behaviour entails a risk of physical infection and scarring, nerve damage and hair loss as well as psychological consequences of shame, guilt, isolation, stress, low self-esteem and depression (Skegg, 2005). Self-harm behaviour affords the individual, the proficiency to express unmanageable feelings, a sense of control, release of pain and tension, a distraction from overwhelming emotion and a way of communicating the need for help.

#### Co-morbidity of compulsive overeating and self-harm behaviour

Extensive research indicates that people who self-harm also often suffer with an eating disorder and vice versa, people who have an eating disorder are also often associated with

higher rates and risk of self-harming behaviour (Claes et al., 2011; Favazza et al., 1989; Kerr et al., 2010; Muehlenkamp et al., 2009; Paul et al., 2002; Solano et al., 2005). A study by Taliaferro and Muehlenkamp (2015) suggests a correlation between individuals experiencing eating disorders and increased risk of developing self-harm behaviour with the incidence and regularity of this behaviour also increasing with the severity of the eating disorder (Turner et al., 2015). Whereas, Zlotnick et al. (1997) claimed to identify no direct relationship between substance abuse (in this case eating disorders) and self-harm without the association of past distressing traumatic events.

#### Experiences of compulsive overeating and self-harm behaviour

There is very limited qualitative research exploring the personal experience of compulsive overeating behaviour, reiterating the need for this current study. However, past qualitative research investigating eating disorders generally have contributed to a broader understanding, such as Curtis and Davis' (2013) qualitative Thematic Analysis provides an insight into the experience of overeating within a sample of obese women both with and without BED. In this study however, reflective of the BED pathology, Curtis and Davis (2013) analysis of the data was diagnostically focused to identify whether the personal experience described by the participants, during a semi-structured interview, corresponded with symptom criteria for Substance Use Disorder within the DSM-5.

Nevonen and Broberg's (2000) qualitative content analysis, offers deeper insight into the aetiology and emergence of eating disorders, revealing themes of interpersonal and weight-related difficulties, causal in the development of eating disorders. Patching and Lawler's (2008) qualitative inquiry advances understanding of women's experiences of developing an eating disorder and recovering, taking a life-history approach. Thematic Analysis of the participant's life experience was reflected upon alongside social and cultural implications, identifying the themes of control, connectedness and conflict. Rørtveit, Åström and Severinsson's (2009) qualitative paper explored women's bodily experiences of suffering from eating difficulties, taking a hermeneutic content analysis approach. Their findings revealed a

main theme of feeling trapped and ashamed within the body with subthemes of physical sensations, devotion to eating difficulty habits, bodily suffering resulting from eating difficulties, judgement from others and hiding and lying to conceal eating difficulty actions.

Qualitative research of eating disorders, utilising YouTube videos however, is very limited, although a few papers, such as Holmes (2017); Pereira, Quinn and Morales (2016), and Veer (2011) have enhanced the broader picture (predominantly focusing on eating disorders in general or AN). Pereira, Quinn and Morales (2016) qualitative study analysed fifty YouTube testimonial videos, discussing eating disorders. Analysis of content and viewer response, applying the inter-rater reliability method for coding qualitative data generated codes which were then studied to establish the overall message. The results of their study reflect a degree of negative feedback to YouTube videos discussing eating disorders, but reveal most of the feedback was positive and supportive, whereas the videos themselves were highlighted as being predominantly posted by females, encouraging introspection and the self-efficacy of emotional support.

Qualitative research investigating nonsuicidal self-harm experience reaffirms the efficacy of this methodology, gaining a deeper insight and understanding of human emotions and behaviour. Whether it is because self-harm is an acknowledged behaviour by the medical and diagnostic community, including the DSM, or whether it is due to pressure from the national health system and society; qualitative research exploring self-harm behaviour is considerably more accessible than that for compulsive overeating. Sinclair and Green (2005) use qualitative thematic and narrative analysis to identify themes within personal accounts of deliberate self-harm recovery, to construct a perception of the recovery process. The main themes to emerge from this study included resolution of adolescent chaos (such as unpredictability of family life), recognition of alcohol as a factor and the acknowledgement of deliberate self-harm resulting from illness.

Crouch and Wright (2004) employed interpretative phenomenological analysis of interviews with adolescents to understand the personal and interpersonal processes involved in deliberate self-harm with emerging themes of self-harm in response to anger and conflict, self-harming for genuine reasons, self-harming for attention, secrecy and difficulty seeking help. Adams, Rodham and Gavin (2005) also utilised interpretative phenomenological analysis to explore the subjective and objective sense of self of participants engaged in deliberate self-harm, revealing a dominant theme of validation with sub-themes of the intrinsic self, describing the participants “expressed sense of inadequacy about themselves” (Adams, Rodham & Gavin, 2005, p.1300) from a particularly negative standpoint; the extrinsic self, illustrating the participants sense of themselves based on external information; the accepted-denied self, describing self-acceptance through acceptance from others and the normal-abnormal self that describes the sense of an abnormal self in comparison to others.

Surprisingly and supportive of this current study, there is limited qualitative research investigating the personal experiences of self-harm behaviour through YouTube videos, although, a content analysis conducted by Misoch (2015) explores online self-disclosure and the role of visual anonymity through YouTube videos, relating to self-harm and a study by Lewis et al. (2011) investigated the scope of nonsuicidal self-injury on YouTube applying a mix-method analysis, revealing potential normalisation and reinforcement of behaviour. Other research exploring self-harm and utilising YouTube as a source of data, has addressed the content and use of imagery in YouTube videos (Duggan et al., 2012; Lewis & Baker, 2011) and trends in viewer comments and responses (Bragazzi, 2014; Rodham et al., 2016; Lewis & Arbuthnott, 2014), but this research is predominately quantitative in nature.

### Why YouTube

A number of past research studies have utilised YouTube videos for the purposes of content analysis (Yoo & Kim, 2011, Hussin, Frazier & Thompson, 2011, Keelan et al., 2007), thematic analysis (Baker & Lewis, 2013, Gao et al., 2013, O'Rourke et al., 2011 ) and coding analysis (Lewis et al., 2012), including limited studies on self-harm previously mentioned (Lewis et al.,

2011; Misoch, 2015). YouTube is an online video sharing platform created in 2005, providing free video streaming for more than 1.5 billion users (YouTube.com) to upload and edit videos, make comments on videos, and create playlists. Every month, 8 out of 10, 18-49 year olds watch YouTube with more than 300hours of video being uploaded to YouTube every minute (Brandwatch, 2017).

YouTube is a significant and unique data resource (Chenail, 2011; Giglietto, Rossi and Bennato, 2012) in which individuals are able “to express themselves in ways that may be constrained in their real-world interactions” (Rodham and Gavin 2006:95). Due to the psychological sensitivity and high risk of triggering inherent with compulsive overeating and self-harm behaviour, YouTube provides a platform for individuals to anonymously and voluntarily share their personal experience without the risk of direct exposure or further harm that could ensue from a survey or personal interview format.

### Labels vs Identity

Throughout this research, careful consideration has been afforded to individuals experiencing self-harm and compulsive overeating behaviour concerning labelling. Labels offer a universally accepted (and often challenged) language for description of experience, a social categorisation and many people welcome and value positive labels and even diagnostic labels, as they afford a sense of belonging and identity (Buckingham & Best, 2017). However, labels can also be assumptive, demoralising, generalising and stigmatic, often neglecting and superseding the individuality and experience of the person (Buckingham & Best, 2017), described by Braun & Clarke (2006) as to “put the condition before the person” (Braun & Clarke, 2006, p.300). In this research, the labels of ‘self-harmer’ and ‘compulsive overeater’ have deliberately not been applied, to acknowledge and respect the participant’s individual personal experience and identity as separate from self-harming or compulsive overeating behaviour.



### Statement of the problem and research question

Due to the secretive nature of self-harm (Adams, Rodham, & Gavin, 2005) and the relatively under-identified compulsive overeating behaviour, YouTube presents itself as a valuable resource and opportunity to explore and understand the similarities, differences and overlap between these behaviours through the Thematic Analysis of shared personal experience. Compulsive overeating behaviour is under-researched, under-acknowledged and too often misunderstood and confused with other disorders such as BED. The lack of understanding and insight into eating disorders that do not meet the AN, BN or BED criteria and thus fall into the 'Other specified feeding and eating disorder' (OSFED) and 'Unspecified Feeding or Eating Disorder' (UFED) (American Psychiatric Association, 2013) classifications, has, to date, only been considered from an emotional regulation, behavioural and neurobiological perspective. This highlights a gap in the research of a lack of understanding and insight into the intrapersonal and interpersonal processes underlying this behaviour. Similarly, although there is qualitative research available that has explored self-harm behaviour, this research is limited comparative to the large pool of quantitative findings which offer clarity and definition but lack depth and rigour of personal experience.

Subsequently, the aim of this study is to utilise qualitative Thematic Analysis (Braun & Clarke, 2006) methodology to complete a comprehensive analysis of the personal experience of the participants, to explore the fundamental emotions, thoughts and processes of compulsive overeating and self-harm behaviour and develop "meaningful findings" (Patching & Lawler, 2009, p.10). The research question at the heart of the study is: *How do those who have compulsive overeating behaviour differ from those who self-harm?*

(3,354)

## **Methodology**

### Epistemological and ontological position

This research comprises of a qualitative thematic analysis of personal experiences shared through the platform of YouTube. Considering the qualitative nature of this study, the ontological and epistemological stance of the research, is of philosophical and comprehensive relevance (Carter & Little, 2007; Klenke, 2016; Willig, 2013). Ontology is the study of being, of existence. Our ontology defines our beliefs about reality, questioning what is truth and how truth is defined (Willig, 2013). The research was approached from an ontological relativist perspective, with an underlying belief in the existence of multiple realities and the adaptation and evolution of truth. Truth is believed to be created by meaning and experience and cannot be generalised, as reality is constantly undergoing transformation (Morgan & Smircich, 1980).

This ontological perspective dictates the epistemological stance of the research, that of social constructionism. Epistemology is the study of knowledge and how human beings attain and justify that knowledge, in other words, how do we know, what we know (Dillon & Wals, 2006). Knowledge and truth are created by society, gaining meaning only because we give something meaning (Willig, 2013). The social constructionist approach suggests we understand truth as what we define truth to be, created in interaction with other people and in our reactions to the expectations of society, social forces and cultures (Burr, 2003; Gergen, 2003; Morcol, 2001).

### Research Design

There is considerable sensitivity, vulnerability and risk of triggering, concerning individuals who have experience of eating disorders and self-harm behaviour (Pallister & Waller, 2007; Whitlock, Lader & Conterio, 2007). Therefore, the decision to analyse the experience of individuals through the public domain of YouTube enabled access to unparalleled, unconstrained and undirected personal experience whilst avoiding any risk of involuntary exposure to the individuals included in the study. The design of the study is a qualitative Thematic Analysis (Braun & Clarke, 2006) of twenty YouTube videos of individuals sharing

their experiences of compulsive overeating behaviour (n=10), and their experiences of self-harm (n=10). The sample size maintains broad alignment with previous qualitative studies that have used circa 30 YouTube videos: Gao et al., 2013; Chou et al., 2011; Lewis et al., 2010; McDaniel, 2014.

### Sample

This study included 20 videos. The age of all participants was determined by appearance, voice and video content to be 18+ years old.

### Inclusion & Exclusion Criteria

The sample included individuals who had voluntarily uploaded their experience and recovery of compulsive overeating and self-harm behaviour to YouTube. Recordings were selected based on specific inclusion and exclusion criteria. The inclusion criteria detailed the video should be a first-person verbal account of compulsive overeating and self-harm experience, feelings, thoughts, emotions, triggers, behaviour and recovery with the individuals' appearance and content of video being indicative of age 18+. All genders, race and culture were included providing the recording was English speaking and good quality audio.

Exclusion criteria for the videos included advertisements and videos related to Anorexia Nervosa or Bulimia Nervosa, Treatment centres or weight loss solutions. Additional exclusion criteria included videos showing only images, videos where the individuals appearance or the content suggested an age below 18, videos suggesting individuals are currently self-harming, videos exceeding 1 hour in length and videos containing graphic material or suicidal content.

### Search parameters

Search parameters for identifying the YouTube videos comprised: 'compulsive overeating story', 'overeating story', 'compulsive overeating', 'overeating', 'compulsive food addiction story', 'self-harm recovery story', 'self-injury recovery story', 'recovery from self-harm'.

Several searches of YouTube were conducted over a period of three months. Once identified as potential sample data, the YouTube videos were then reviewed by a Supervisor for graphic and/or suicidal content in line with ethical considerations. A total of 24 videos were rejected per the inclusion/exclusion criteria including the following links of self-harm behaviour: graphic content (1), participants under the age of 18years old (5), graphic suicidal content (4), images of scarring (4), discussing self-harm and other disorders (2), talking about someone else's experience (1) and videos no longer available (2). The following links for personal experience of compulsive overeating behaviour were also rejected: unrelated to overeating (1), being under the age of 18 years old (1) and discussing multiple eating disorders (3).

Videos were then approved and transcribed verbatim into Microsoft Word format, noting verbal and non-verbal cues including pauses or laughter and marking line numbers.

### Method of analysis

#### Transcription

Each of the twenty YouTube videos approved were transcribed verbatim into Microsoft Word format, noting short pauses as (.), long pauses as (1) and laughter or other non-verbal cues as (laughs) for example. Each transcription was then marked with line numbers for reference (See Appendix C).

#### Stages of Analysis

The transcripts were analysed applying Braun and Clarke's (2006) six stages of Thematic Analysis. Thematic analysis offers a theoretically flexible methodology for analysing qualitative data (Braun & Clarke, 2006) and is a sensitive and in-depth approach to exploring the phenomenology (Sim, 1998) of an individual's feelings and experience.

Initially, the data collected was listened to, transcribed, read and reviewed several times whilst simultaneously watching and listening to the videos. Initial thoughts and responses to the data

were noted down to facilitate a familiarisation and engaging with the data collected (Braun & Clarke, 2006).

In the second stage of the process, common and unique codes from initial observations and reactions to the data were noted in the margins on the transcriptions (See Appendix D). The codes captured the semantic and conceptual tones of the data (Braun & Clarke, 2006), respecting the uniqueness of each experience whilst noticing social and cultural commonality between the experiences, relative to the research question.

The third stage of the analysis entailed inputting the codes into Microsoft Excel format (see Appendix E), with referenced transcription and line number (e.g. CE001/22 = Compulsive overeating transcription 1 / Line 22), followed by a grouping and sorting of the data, searching for associations, interactions and relationships within the codes, described by Braun and Clarke (2006) as “theme-piles” (Braun & Clarke, 2006, p.89). Throughout the ‘searching’ stage, respect, thought and consideration was given to the personal thoughts, feelings and experience of the participants represented by the generated codes, to avoid ‘getting lost’ in the data. This process of reviewing, reflecting, ruminating and feeling the data alongside the search for relationship and association among the codes, facilitated an emergence of several key themes. Themes represent connections and patterns within the data relating to the research question (Braun & Clarke, 2006) that emerge from the coding and familiarisation steps of analysis.

The fourth stage of the analysis involved reviewing the emerging themes against the original transcriptions, the “data corpus” (Braun & Clarke, 2006, p.79) and codes looking for and understanding the emotional, psychological and behavioural relationships between the themes. It was helpful during this stage to create a visual, graphical representation of the relationships between the themes (See Figure 2, page 29).

The penultimate stage of the process saw a detailed refining, defining and naming of the revealed themes in preparation for presenting the findings from the analysis in the study.

In the final stage of the thematic analysis, extracts and examples were selected from the data, relating the analysis back to the research question and supporting the findings reported. The research question, '*How do those who have compulsive overeating behaviour differ from those who self-harm?*' directed the focus of this analysis in seeking similarities, dissimilarities and overlap of concepts between compulsive overeating and self-harm behaviour.

### Reflection

The analysis process was enabled by the context of the data, as exploring the participant's experience, shared on YouTube, offered a unique opportunity for undirected and in most cases deep, unreserved personal insight into the world of the participants. The initial, thoughts and feelings of the researcher of the transcribed YouTube videos were of empathy and compassion for the participants and construction of themes was enabled and facilitated by both the researchers' personal response to the participant's experience as well as from a professional perspective as a Psychotherapist, noticing the participant's conscious and unconscious processes. The researchers' psychological awareness of self and emotional empathy for the participants offers the analysis a balanced and open perspective of experience.

### Ethical considerations

Ethical consideration was given and applied to the selection process of YouTube videos by ensuring that all YouTube videos were previewed by a Supervisor for graphic or suicidal material prior to approval and inclusion (Simpson & Wilson-Smith, 2017). Transcribed recordings were anonymised to protect the identity of the participants and all names/locations and identifying factors in the recordings were replaced using pseudonyms. Direct quotes from the transcriptions have been used as traceability through search engines should not be possible given that the data is verbal (British Psychological Society 2013; Rodham and Gavin

2006). Using YouTube material (in the public domain) reduces the risk of harm to vulnerable individuals, however as YouTube uploading is open to all individuals aged 13 and above, every effort has been made to ensure that any videos of those under the age of 18 were not sampled.

Per the BPS Guidelines for ethical practice in psychological research online (2013), observation of public behaviour needs to take place only where people would 'reasonably expect to be observed by strangers' (British Psychological Society 2009, p.13). Content on YouTube is freely and publicly accessible, and as such consent is assumed.

This study complies with the British Psychological Society code of ethics and conduct (British Psychological Society, 2009) and has received ethical approval from the University of Chester Ethics committee.

(1,438)

## Analysis

Data was analysed using Braun & Clarke's (2006) six stages of Thematic Analysis, to answer the research question, "*How do those who have compulsive overeating behaviour differ from those who self-harm?*". 18 themes were generated, presented in the Thematic map of YouTube videos (See *Figure 2*) with the relationships between the themes outlined as follows.

*Life experience* was the first theme to emerge from the data, feeding into and shaping the individuals' *emotional wellbeing*, *sense of belonging* and *support structure*.

From emotional wellbeing, sense of belonging and the degree of support available to the individual, levels of *self-esteem* and sense of self are established which directly contribute to experiences of *shame* and *isolation*. As a way of managing shame and isolation, the theme of *control* arises leading to the establishment of *coping strategies* and *behaviour* to regain emotional, psychological and physical control. The theme of *consequences* emerged resulting from these coping strategies and behaviour. Stemming from emotional, psychological and physical consequences experienced by the individual are levels of *motivation*, *action*, use of and acceptance of *labels*, *honesty*, *awareness* and *acceptance*, completing the process with varying degrees of *accomplishment* and ultimately reinforcing positive or negative emotional wellbeing, a sense of belonging, self-esteem and the need for support.



## Understanding the relationships between the emerging themes

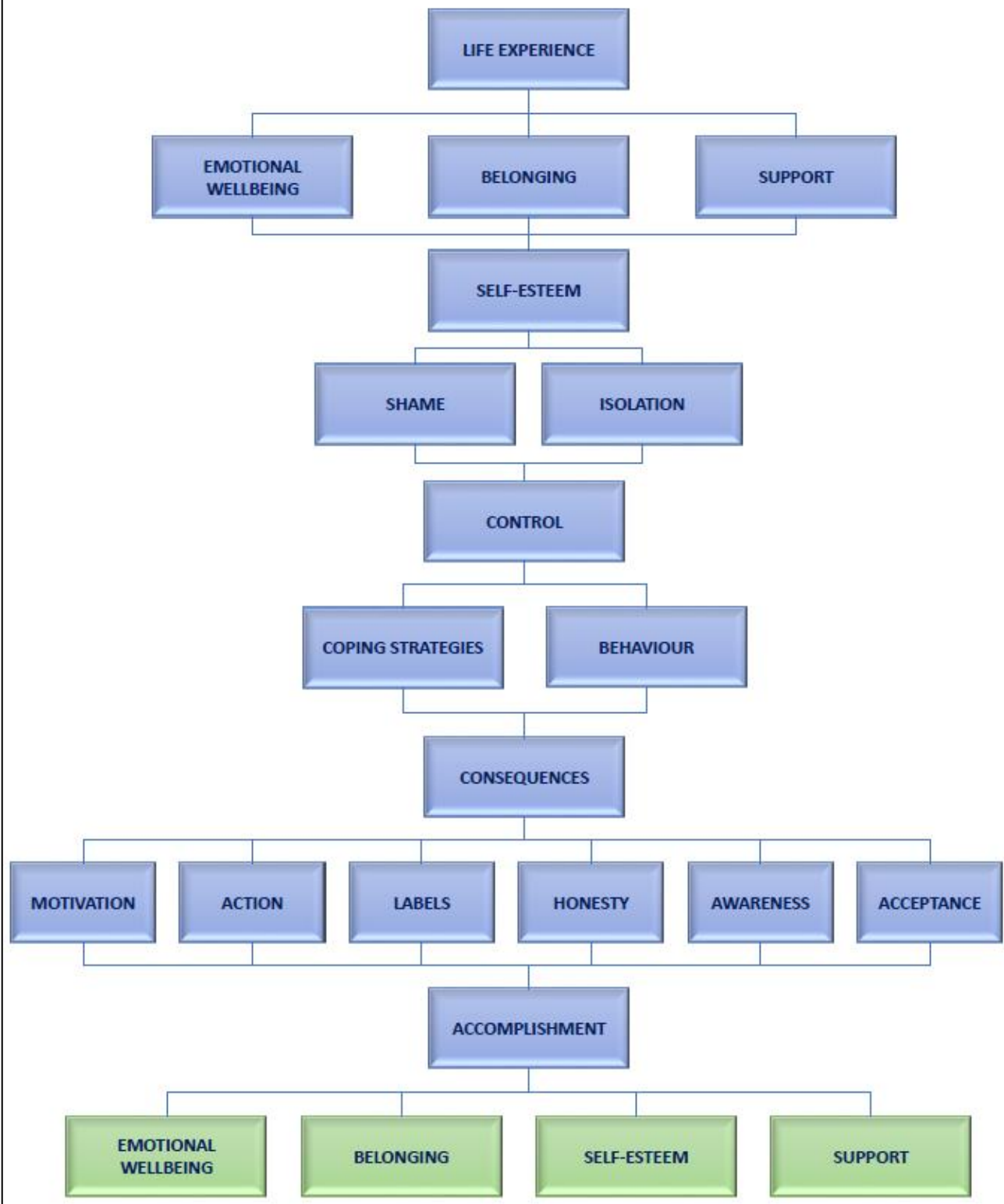


Figure 2. Thematic Map of the YouTube videos.

Each of the identified themes is defined and supported by examples and extracts from the data corpus (Braun & Clarke, 2006), referenced in the format of Compulsive overeating or Self-harm experience, transcription number and line number for example: Compulsive overeating, Transcription 1, Line 11 - CE001/11.

## **Life Experience**

Life experience encompasses familial environment, childhood memories, major life events and life phases such as adolescence. The participants talked freely about their life experiences in the YouTube videos, although their volume, tone, pace and body language suggested that in most cases, it was still very difficult to talk about their experience.

### Early memories

Early memories emerged as a significant sub-theme with many of the participants reflecting on memories from a very early age. Several participants talked about early memories relating to emotions, how they had felt and their need for familial support and validation, as well as memories of past compulsive overeating and self-harm behaviour. Some participants felt that families were not emotionally available for them.

*“I’d want her to just come and see me (.) Most of the time she didn’t wanna deal with it so (.) There’s a pretty wide gap under my door and she used to just shove sandwiches under the door (.) Instead of giving me a hug (.) you know (.) I got a sandwich so (.) To this day sandwiches are like one of my biggest comforts (.) (CE001/12-17)*

This example of a participant needing comfort from her Mother and being given food in place of emotional support, is representative of several of the participants, relating present feelings and behaviours to childhood experience thereby developing self-awareness and the ability to connect the current emotional relationship with food with memories. Other participants attributed overeating from an early age to a lack of knowledge, inability to make healthy food choices and an awareness of an inexplicable obsession with food.

Other participants attributed confusing experiences when they were young to their self-harm behaviour.

*“I was eight years old (.) I didn’t really understand what was going on (.) I had no idea how to comprehend or just wrap my head around the fact that I would never see my mom again (.) (SH007/16-17)*

The participant describes trying to “*comprehend*” losing her mother at a young age, offering an insight into her world as a child and what she was trying to emotionally process. Whether real or perceived, many of the participants who have experienced self-harm behaviour, allude to a lack of familial and/or peer support as a child and consequent lack of self-awareness and ability to understand and process emotions.

### Life events

Specific life events such as pregnancy, divorce and death were described by several participants as events that were difficult to emotionally and psychologically manage and process.

*“A few months later I found I was pregnant with xxx and my biggest fear was (.) um (.) well my biggest (.) biggest fear was surviving another round of postpartum depression potentially and also I just didn’t want to do to my body what I had done with it with xxx (.) I didn’t want to be sick and gain 50 pounds” (CE008/110-112)*

The participants experience suggests feelings of pressure and lack of control, exacerbating the need for or in some cases already developed, coping strategy. The participants with experience of compulsive overeating behaviour, describe an emotional, body focused response to life events.

*“My parents did split up when I was about two years old (.) And at the age of eight (.) my mother actually passed away (.) (SH007/13-14)*

Participants with experience of self-harm describe difficulty understanding and managing emotions, creating a need for control. This difference in response to life events is important as it suggests participants who compulsively overeat avoid their response to life events with body preoccupation and behaviour whereas participants who self-harm seek control over their emotions and response.

### Adolescence

Those who identified as having compulsive overeating behaviour discussed the impact across the lifespan, with an awareness of overeating behaviour emerging at an early age and continuing through life.

*“I was born a normal (.) healthy weight and I think I started turning to the food from a very early age (.) (CE003/2-3)*

Here, the participant describes a “*turning to*” food when he was young, implying early connections between food and psychological comfort in addition to physical sustenance. Other participants described the onset of compulsive overeating at school age. The participants experience suggests school pressures and the need to be accepted are reasons for the onset of this behaviour, whereas others described food as an “*emotional crutch*” (CE002/11), available to ‘use’ “*the minute anything goes wrong*” (CE002/12).

*“14 is such a shitty age anyway (.) you know? Especially like (1) When you’re a teenager life is (.) everything that happens in life (.) you know (.) it- it is a mixture of melodramatics but it hits you” (SH005/35-36)*

This participant repeatedly describes adolescence as being difficult, stressful and overwhelming, radically affecting her self-esteem, self-acceptance and feelings of belonging with others.

*“really badly self-conscious (.) I hated myself (.) I (.) um (.) I had really misplaced feelings of where I belong (.)” (SH005/27-28).*

The overwhelming intrapersonal and interpersonal experience described by the participants was attributed to the onset and decline of self-harm behaviour during adolescence. Whilst nine out of ten videos support adolescent onset, one participant described the onset of self-harm behaviour at the age of 35 (SH008/5).

## **Emotional Wellbeing**

The participant’s level of emotional wellbeing was identified as significant to the onset and recovery from compulsive overeating and self-harm. Deeper insight was gained into the relationship between the emotional state and life experiences of the participants, exploring sub-themes of emotional maturity, negative emotional experience and positive emotional experience in relation to the participant’s behaviour.

### Emotional maturity

Emotional maturity emerged from the broad description of participant’s feelings when describing their thoughts and emotions in relationship. Participants with experience of self-harm described feelings of difficulty coping and talking about their experience.

*“it’s been really useful for me to actually sit here and talk about it (.) and tell my whole story in one go (.) because it doesn’t happen very often (.) Um (.) I kind of skip over bits when I’m talking to people and it’s a bit of an awkward subject (.) it’s just (.) it’s still a (.) very much a taboo subject to talk to people about (.)” (SH004/201-204)*

Above, the participant describes reluctance to talk about his experience with others because it feels “*awkward*”, he acknowledges his behaviour as a “*taboo*” subject. This insight implies a risk of exposure and vulnerability, offering rationale for sharing personal stories through YouTube. Other participants described intrapersonal difficulty, verbalising their experience to others.

### Negative emotional experience

Anger was a significant negative emotional experience predominantly for participants with experience of self-harm behaviour. The participants described their experience of anger, directed towards themselves, their environment and others as well as experiencing anger from others toward them.

*“Once I was done I’d be like (.) “Ugh (.) I’m such an idiot (.)” (CE001/36)*

Interestingly, anger was not specifically mentioned by any of the participants with compulsive overeating behaviour, although often their construction of themselves was, as above, self-deprecating, implying an unconscious anger towards the self.

*“I am so angry at myself that these six years (.) you know (.) that they were almost wasted being angry with myself and hateful towards my body and my self (.)” (SH005/139)*

Above, the participant describes her feelings of anger, relating her self-harm behaviour as the physical manifestation of anger. Other participants described an emotional need to release anger, “*letting out anger*” (SH009/37), connecting the feeling with the physical behaviour, and “*taking out anger on ourselves*” (SH009/37). Many participants expressed discomfort and a lack of experience with feeling and releasing anger outwardly, consequently internalising the feeling. Not all participants however, described experiencing anger, instead describing

depression, anxiety and overwhelm, possibly intensified by other people's anger towards them (SH004/46).

Anxiety and panic attacks were identified as a response to overwhelming emotion and life experiences, as well as a consequence of the behaviour of compulsive overeating and self-harm.

*“they put me on antidepressants (.) which were mostly (.) they're mostly to deal with anxiety (.) because I was having panic attacks (.) And it was like (.) the feelings of anxiousness (.) and like (.) I would (.) would work myself up into a state (.) at which I self-harmed (.)”* (SH004/149)

Participants with experience of self-harm reported more instances of panic attacks and uncertainty. Both groups however, described intense anxiety with participants experiencing compulsive overeating behaviour attributing anxiety to disordered eating patterns, weight fluctuations and social pressure and participants with self-harm behaviour attributing anxiety to emotional overwhelm.

The relationship between emotional wellbeing and behaviour was also observed throughout the analysis.

*“Um (.) with my emotions being so up and down (.) I turn to food (.)”* (CE002/12)

This suggests, that the emotional “ups and downs” experienced by participants with compulsive overeating behaviour, may reflect the irregular and disordered patterns of eating behaviour.

*“That was really helping fill (.) um (.) this void that I was feeling at the time (.)”*  
(CE010/27-28)

The relationship between emotional and physical wellbeing is again supported by the participants description of physically filling an emotional “void”. The attending to emotional needs through physical actions was described by both groups.

*“It was to kind of quieten everything in my head and numb everything (.)” (SH008/17)*

Here, the participant describes his experience of self-harm, making him feel peaceful and emotionally numb, offering insight into the motivation and intent for his behaviour. Several participants described an emotional “sense of numbness” (CE010/69) resulting from compulsive overeating and self-harm behaviour.

Both groups described seeking emotional numbness especially from feelings of sadness, depression, grief and loss. Like anger, these feelings were presented , as being severe, imprisoning and unmanageable.

*“I was so desperate for it to be fixed (.) for all of it to be fixed (.) for this darkness of depression I was living in (.) for this body that I hated because it was foreign to me (.) Um (.) I felt like I was just trapped and I couldn’t do anything about it (.)” (CE008/156-158)*

Here, the participant describes her experience of depression as being like a “darkness”, of feeling “trapped”. Her desperation is evident in her need to be “fixed”, language that elicits the sense of something being broken. Many of the participants described feeling depressed as one of the reasons compulsive overeating and self-harm, although the cause of depression was not discussed. Other participants described difficulty emotionally coping with feelings of loss and overwhelming grief.



The analysis suggests overwhelming emotion is compounded by cumulative stress of everyday life and traumatic experiences. Both groups described trying to emotionally and psychologically cope with stress of work, family, children and self-expectations in addition to stress created by compulsive overeating and self-harm and in some cases on top of traumatic experiences of death, confrontation and family conflict.

*“I remember thinking at one point that I couldn’t (.) like I just remember thinking (.) “My life is too hard right now (.) My life is too stressful right now (.) Food can’t be on my mind (.) I can’t worry about eating healthy (.) That’s just not something that can’t be on my plate right now because my plate’s too full” (CE008/193-196)*

Here, the participant describes her struggle with feeling overloaded, perceiving her life as “*too stressful*” and implying that eating unhealthily and preoccupation with food is compounding her emotional unmanageability. Her language and phraseology of her “*plate’s too full*” is interesting, suggesting an unconscious process with compulsive overeating behaviour.

Feelings of frustration, fear, regret and powerlessness were discussed by several participants in their experience of compulsive overeating and self-harm behaviour.

*“I haven’t relapsed very often (.) since I kind of mostly stopped (.) Um (.) but when I have it’s really (.) really terrifying (.) And if you’ve done it too (.) it like (.) you think (.) “Oh my god (.) I’m gonna (.) I’m gonna go back to that place that I was in (.) I’m going to be in that mental state that I was in when I was doing it all the time (.) and how am I going to cope with it? How am I going to get through it again?” (SH004/173-176)*

In this extract, the participant is trying to control her feelings and behaviour, suggesting a struggle with abstinence from self-harm, being “*mostly stopped*”, despite how the behaviour makes her feel. The language used, “*cope*” and “*get through it*” suggests self-harm behaviour

is challenging and confining. Several participants described fear and frustration, especially relating to a relapse of behaviour.

### Positive emotional experience

Positive emotions such as happiness, gratitude, trust and growth were described as emotional consequences of the participants recovery experience whereas anticipation, euphoria and relief were more associated with engaging in compulsive overeating and self-harm behaviour.

*“the excitement of going to get the food is fantastic (.) It’s something I-(laughs) I enjoy you know (.) That (.) that urge to get the food um (.) knowing you’re going to be eating a very large meal soon (.) it’s something that I look forward to (.)” (CE007/48-49)*

Anticipatory excitement is clear in this participants’ experience of compulsive overeating, suggesting a connection between the physical behaviour of seeking out food and overeating, with the emotional experience. Anticipation was a momentary sensation prior to engaging in compulsive overeating and self-harm behaviour followed by the sensations of euphoria and relief.

Many participants described experiencing a sense of emotional growth and freedom through the process of recovery.

*“I learned to grow through my experiences and I learned that my past did not define me (.) All of the struggle and the pain and the emotional hardship that I’ve experienced has really allowed me to flourish into the woman that I am today (.)” (SH007/64-67)*

Reflecting on her recovery, this participant describes emotional growth using language like “flourish” suggesting an increase in self-esteem and emotional development. Other participants used language like “learning”, “growth” and “accomplishment” to describe their

experience of recovery. The language used by the participants suggests emotional and psychological change through self-learning and growth, encourages recovery.

## **Belonging**

The need to belong, to be part of and to relate to other people emerged for both groups of participants, however participants with compulsive overeating behaviour described their need to belong and connect with others more frequently.

*“For the first time I was able to be in a group of people who I could understand (.) and they could understand me (.) and I could relate to them (.) And I finally felt a sense of belonging (.) (CE003/34-35)*

Here, the participant describes her feeling of belonging with people who mutually understand and can relate to each other's emotional and physical experience. Many of the participants described belonging in terms of being accepted and understood by others, implying feelings of a lack of acceptance and understanding by friends, family and larger society.

*“I had really misplaced feelings of where I belong (.) And you know people underestimate sort of the feeling of belonging (.) feeling like a part of something (.)” (SH005/27-29)*

This participant, with experience of self-harm, also describes the important need to belong. There is a desire to move away from isolation and feel part of a larger “*something*”, suggesting a feeling of disconnection from society. The analysis also suggests that both behaviours exacerbate the need to belong as the behaviours themselves are isolating in nature.

## **Support**

All the participants described a need for help, support, connection and contact with others. Support in this sense was described as familial and peer support, encouragement, listening, understanding, compassion, love and kindness.

*“You’ve got people who love you and who care about you (.) Friends (.) family (.)”*  
(SH005/98)

Many of the participants in both groups described their experience as isolating and secretive due to intrapersonal conflict and fear of anger, criticism, judgement and taboos from society and sometimes friends and family. Seeking support through acceptance, encouragement and friendship was often desired and needed but frequently hindered by the behavioural paradox of needing to isolate.

*“I have people in my life today that help me through the difficult times (.) and I don’t have to sit in isolation”* (CE003 36-37)

Here, the participant describes her experience of compulsive overeating in “isolation” to manage emotional difficulty, being replaced by emotional support from others. Other participants in both groups also described experiencing external interventions by family and friends, forcing them out of the ‘isolation trap’ and creating an environment of support encouraging the control of remission and learning of new behaviour and alternative coping strategies.

### **Self-Esteem**

Both groups of participants described low self-esteem and self-worth, a need for validation, an inner critical voice, self-hate and the sense of feeling a failure. Many of the participants described a relationship between the development and maintenance of self-esteem and body awareness, their behaviour and comparing themselves with others.

*“if I had too many pieces of cake or I ate something that I thought I shouldn’t (.) my self-esteem would just crash and burn (.)” (CE010/51-52)*

Here, the participant describes self-esteem being directly affected by overeating behaviour. The participants dramatic language *“crash and burn”*, implies a detrimental effect to her sense of self every-time she engages in this behaviour.

*“So Monday I’m going to fix it (.) and then I would fail Monday (.) Tuesday (.) Wednesday (.) I would fail by noon every day (.)” (CE008/153-154)*

Other participants described low self-esteem growing up, being caught in a cycle of low self-esteem and compulsive overeating or self-harm behaviour through repeated failure to meet goals and expectations of themselves. Above, the participant describes this cycle, setting her goal, to control and refrain from compulsive overeating, to *“fix it”*. Her language suggests a pre-existing sense of being broken which, coupled with the inability to refrain from the behaviour, subsequently leads to the internalisation of being a failure and low self-esteem, rather than reflecting her behaviour.

Both groups described awareness and lack of appreciation or acceptance for their body or body-image. This overlap of body consciousness across the participants, implies a connection between the psychological processes and these behaviours.

*“always hating your body (.) always squeezing your body (.) always worried if someone thinks that you’re fat” (CE010/133-134)*

In this example, the participant describes her feelings of self-loathing and fear of what other people think of her body and size, suggesting that her measure of self-esteem has a strong external focus. This perspective was common to all participants with experience of compulsive overeating behaviour.

*“I didn’t like the way I looked (.) I was overweight (.) Um (.) I just didn’t like the way I looked at all (.)” (SH002/5-6)*

Contrastingly, and yet still related to body consciousness, the participant above describes herself self-critically, conscious of feeling “*overweight*”, suggesting an internal psychological focus, reflecting the behaviour of self-harm. This perspective of body and body-image was common to all the participants with self-harm experience who talked about their body.

The analysis shows, participants with experience of self-harm behaviour, turn anger and blame inwards. Contrastingly, participants with compulsive overeating behaviour describe a lack of support, criticism and judgement from others as contributory to the onset and decline of their behaviour.

*“me and my parents really had some major arguments over it (.) um (.) but yeah (.) again (.) as I said (.) I don’t blame them at all (.)” (SH004/60-61)*

Participants with self-harm behaviour, repeatedly affirm, others should not be blamed for their behaviour, turning their emotion and feelings back on themselves rather than assigning blame elsewhere.

## **Shame**

Both groups described shame, embarrassment, guilt, a need to hide, a need for secrecy and an overwhelming fear of judgement from others. Fear of embarrassment, exposure, ridicule and humiliation were also described by both groups as being contributory to the need for secrecy and to hide.

*“So I feel like society puts this pressure on people that makes them feel like you can’t talk about it (.) because if you talk about it (.) you’re going to be called names (.) and*

*you're gonna be made fun of for it (.) because people think that it's stupid (.)"*  
(SH010/54-56)

Here, the participant describes feeling “*pressure*” not to talk about self-harm behaviour, owing to a perceived lack of knowledge and understanding in society. His belief was that talking about self-harm would lead to ridicule and demoralisation. Other participants described exposure of their behaviour to others as triggering of the behaviour itself, due to the overwhelming feelings of shame.

*“I would just be on this vicious cycle when I was with him (.) and I guess I felt like I had to (.) uh (.) like (.) kind of hide it (.) so I did that (.) and (.) um (.) so I secretly would just eat and I'd feel awful (.) uh (.) I (.) oh (.) I would just feel so bad after I did it (.)"*  
(CE006/40-42)

The participant above, describes her need to hide her behaviour to avoid criticism and judgement for her actions. The language used by the participant of “*needing*” to hide implies necessity, emphasising her feelings of shame and guilt. Other participants used language such as “*empty*”, “*ashamed*”, “*broken*” and “*hopeless*” to describe their feelings of shame.

## **Isolation**

The participants described difficulties of loneliness and feeling alone before experiencing recovery is substantiated by their repeated assurance to others that they also, do not have to feel alone.

*“I would get really anxious if people would ask me to go out to lunch (.) because that meant that I wouldn't be able to binge in front of them (.) I would have to order a salad and play it off like- like I didn't have any problems with food (.) So (.) um (.) it's just a really depressing (.) dark (.) lonely world that you live in and you're trapped in it (.)"*  
(CE009/51-52)

Here, the participant describes loneliness whilst at a social event involving people and food. She describes anxiety and a need to inhibit her eating habits to conform, suggesting no-one is aware of her internal conflict. Language such as “*depressing*”, “*dark*” and “*lonely world*” evokes a sense of hopelessness and lack of help or support. Many of the participants described shame, the need to hide, keep secrets and withdraw from society, thereby reinforcing isolation and self-sufficiency and leading to loneliness.

## **Control**

The participants described their need to identify a way of controlling unmanageable and overwhelming emotional experience. This need was met by compulsive overeating and self-harm behaviour. Once the participants began engaging in this behaviour however, various control mechanisms were required by the participants, to be able to control the behaviour itself, such as dieting, changing eating behaviours, monitoring weight, secrecy and willpower.

*“most people have a form of “food addiction” as they say (.) But for me the progression in my life is when it got so out of control that I no longer had the power to change it (.)”*  
(CE008/243-248)

In this example, the participant describes a “*progression*” implying that compulsive overeating behaviour had developed and increased in severity. It is interesting that compulsive overeating behaviour elicits a sense of life feeling out of control whereas self-harm behaviour is often described with the behaviour feeling out of control.

*“it was really hard to (.) um (.) cope with those things (.) so self harm really helped me to kind of be able to control something in my life (.) It just felt like I was able to control what I was feeling (.) that kind of thing (.) And then from there (.) it progressed into not being able to control it (.)* (SH010/21-24)



Here, the participant described difficulty coping with his *“troubled childhood”* (SH010/17), leading to self-harm behaviour which gave him a sense of control over what he was feeling. He alludes to the sense of having no control over anything in his life, thus self-harm provided him with control over *“something”*. Like the participants with experience of compulsive overeating, he describes a *“progressing”* of his behaviour, resulting in feeling out of control.

## **Coping Strategies**

Both groups discussed attempts to regain control over themselves, other people and their environment by establishing coping strategies. Both compulsive overeating and self-harm behaviour are coping strategies used by the participants to manage and establish control over their feelings.

*“when I first started I was self-harming and I was using that as a way to make myself feel better (.) Um (.) it was like a release really (.) just to make myself feel better when I was feeling a bit down (.)”* (SH002/23-25)

Here, the participant describes self-harm behaviour as being a *“release”* of emotion, suggesting an accumulation of pressure and reaffirming the behaviour as a coping strategy, *“a way to make myself feel better”*.

All the participants described an awareness of their behaviour as being a coping strategy, and need, for alternative or positive coping strategies.

*“Food was my drug (.) It was my way of coping with pain (.) with humiliation (.) with fear (.) with all of that (.)”* (CE003/20-21)

This participant illustrates awareness of using food as a coping strategy for managing emotion, describing food as a *“drug”*, which implies food has a medicinal or addictive quality. It is

possible, however, that this awareness has formed part of the recovery process and may not have been present when the coping strategy was employed.

The coping strategies of compulsive overeating and self-harm behaviour, for all the participants, were progressive, internalised and evolved into repetitive, intrusive thoughts, or obsession of compulsive overeating and self-harming.

*“you think about it all the time when you’re self-harming when you’re in that state (.) because you’re either (.) You’re in pain from it (.) Every time you move you can feel it (.) and (.) um (.) every time (.) I don’t know (.) I got into such a state every time I saw a sh(.) sharp object I was thinking about it (.) And even if somebody had a cut on the back of their h.(.) a paper cut (.) I would be thinking it (.)” (SH004/68-72)*

This participant implies she has a history of self-harm behaviour and describes her preoccupation with thoughts of self-harming even when there is no emotional necessity to self-soothe or emotionally regulate herself. The participant describes a persistence to her thoughts, an obsession with self-harm, exacerbated by triggers of physical pain and visual stimulation from sharp objects or wounds. Other participants also described repetitive, intrusive thoughts of self-harming.

In addition to obsessional thoughts of compulsive overeating and self-harm behaviour, many of the participants in both groups also described the progression of a behavioural need.

*“I’m going to start self-harming again (.) I know it (.) I can’t (.) I can feel it(.) I can feel the feelings that I use to have all over again (.)” (SH004/146-147)*

In this extract, the participant describes her experience of compulsion with self-harm behaviour, recognising the feelings leading up to self-harming behaviour yet implying a lack of conscious control and behavioural urges. Others described these feelings as urges to

compulsively overeat or self-harm, an internalised unconscious drive and compulsion, with or without the underlying need to regulate emotion.

## **Behaviour**

This theme highlights the few differences identified in the behaviours of compulsive overeating and self-harm and similarities and overlap of the physical and psychological processes underlying these behaviours. Participants who had experienced compulsive overeating behaviour described experiencing behaviours of self-blame, calculation, variability, concern with the impact on others, being boundaryless, concern with quantity, repetition, speed of eating and bingeing.

*“I came home and with this sadness was kind of (.) um (.) just sort of lurking in my heart (.) I didn’t know (.) I felt really uncomfortable with it (.) I didn’t know how to support it (.) I wasn’t really able to support it (.) so instead I went to the kitchen and I got some cereal (.) and then after the cereal I had some cheese (.) and after the cheese I had some chips (.) I finished the bag of chips and then I took the bag and stuffed it real down far into the trash so (.) my fiancé at the time (.) wouldn’t know that I had eaten a lot of food in the house (.)” (CE010/61-67)*

In this extract, the participant describes emotional overwhelm and discomfort. She suggests awareness of the need for “support” because she was feeling sad, but she implies that she was unable to emotionally regulate or self-soothe herself without using food. The participant describes consuming various foods in an uncontrolled and boundaryless way, supporting quantity as important in the behaviour of compulsive overeating. There is also concern of exposure, thus a sense of concealment is evident in the participants behaviour. The behaviour of emotional regulation with uncontrolled and secret consuming of large quantities of food was also described by other participants.

Participants with experience of self-harm described behaviours of cutting, escalation, importance of frequency, prevalence of behaviour at night-time, feelings of punishment, ritualism, concern with upsetting others and feeling urges to self-harm.

*“it is a slippery slope and very quickly (.) it becomes more and more serious (.) So you might start with something that is not extreme at all (.) it might not even leave any marks (.) but it very quickly and very rapidly can get out of control (.)”* (SH009/28-30)

This participant described escalation with self-harm behaviour, going downhill, getting worse and increasing in severity. There is a sense of momentum in the language used, “*serious*”, “*extreme*” and “*rapidly*” suggesting an internally driven need for the behaviour to become more frequent. Several other participants also describe their experience of escalation with emphasis on the speed of escalation.

Several areas of overlap between both groups’ behaviours were revealed in the analysis such as destructiveness, extremity, impulsiveness, needing to help others, experiencing progression, relentlessness of behaviour, experiencing a spectrum of severity and becoming isolated.

*“And then I was old enough to drive (.) and that opened up a whole new world to me (.) which was fast food (.) Almost every day I was going (.) And then when things got really bad I was going more than once a day (.) twice a day (.) uh (.) even three times a day (.) And I would not just get one fast food meal (.) I would get three or four (.)”* (CE003/8-11)

Here, the participant describes a sense of freedom as a “*whole new world*” of opportunity to overeat has become available to him. He describes progression of behaviour with an increase in frequency of overeating and an increase in quantity of food over time. Despite his awareness of the physical and psychological consequences of his behaviour, the participants’

behaviour continues to escalate. A few of the participants described a similar escalation of behaviour despite a conscious desire for the behaviour to cease.

## **Consequences**

Both groups frequently talked about and described experiencing consequences to their behaviour of compulsive overeating and self-harm. Participants with experience of compulsive overeating behaviour described experiencing consequences of weight gain and loss, being overweight, reaching breaking point, suffering health problems and experiencing physical sickness.

*“At that point I was 500 pounds (.) I would climb a flight of stairs and my heart would be pounding so hard that my vision would literally pulse in front of me (.) (CE003/12-13)*

Here, the participant describes feeling physical strain and health problems whilst engaging in normal daily activity, due to being overweight. Interestingly, whilst physical health problems and weight gain were not a direct catalyst for change in this and many of the other participants, they were symptomatic of progression of compulsive overeating, which in most cases led to a need to change.

The participants with experience of self-harm behaviour described their unique experiences of the consequences of self-harm including physical pain, feeling stuck and trapped, needing to cover up and hide and manage physical marks, wounds and scars.

*“I self-harmed quite severely (.) so there would be a huge management of having to dress it (.) and having to get to hospital (.) and having to get stitches (.) and that whole kind of routine for me (.)” (SH008/15-16)*

This participant constructs his self-harm as serious and something he “*manages*”, despite having encounters with the medical profession in order to do this. He presents his self-harm management as “*routine*” despite being reliant on others for help.

Overlap of consequences were identified in both groups’ experiences such as a cycle of behaviour, a sense of being trapped and a sense of freedom both when acting on the behaviour and when experiencing recovery from the behaviour.

*“I really could not see a way out of compulsive eating (.) because that’s what was bringing me solace (.) That was really helping fill (.) um (.) this void that I was feeling at the time (.) this sense of pain and this sense of sadness (.) (CE010/26-28)*

This participant describes feeling trapped in the behaviour of compulsive eating, unable to break the cycle because the behaviour brought her peace, described in her words as “*solace*” and helps her to manage sadness. She describes experiencing food as filling the emotional emptiness within her as well as enabling her to manage her feelings.

*“The trouble is self-harm (.) is you kind of do it (.) and then you feel really bad about yourself again (.) so there’s this constant cycle of kind of feeling even worse about yourself (.) feeling like you’ve let yourself down (.) let other people down (.) and it just perpetuates this feeling of you not being a good human being (.) (SH008/61-64)*

This participant describes a perpetuating cycle of self-harm behaviour followed by feelings of inadequacy, disappointing others and shame. The participants description however, is introspective with no input from other people, the cycle is formed by her own thoughts, feelings and behaviour. It is possible therefore, that the cycle of self-harm could be interrupted by external intervention.

## **Motivation**

Participants described what prevented and what encouraged their recovery and a change in behaviour from negatively destructive to positively constructive. The participants with experience of compulsive overeating described barriers to recovery such as a need for inspiration, energy and incentive.

*"I had lost enough weight to ride a bike for my first time since I was uh 15 years old (.)  
It's driving me to keep on working and to keep going (.)"* (CE001/51-52)

Here, the participant describes his experience of losing weight and being able to exercise, an experience he has not had in a long time. The use of words like "*driving me*" implies he is motivated whilst also acknowledging his need, "*work*", to continue experiencing recovery. This experience suggests that motivation and effort are required to experience recovery from compulsive overeating.

Participants who had experienced self-harm behaviour described a lack of motivation as preventing a change in behaviour and new experiences, opportunities and rewards as encouraging recovery.

*"not long after (.) we're across on a boat trip and just had the most amazing time of my life (.) and the most intensely rewarding experience of my life (.) And cycling proved to be such a good tonic for all my (.) you know (.) the problems (.) I felt such peace of mind (.) 'cause I was (.) you know (.) being physically active"* (SH006/48-49)

Following a period of suicidal depression, this participant was invited to go travelling and cycling abroad with a friend. He describes the value of new experience for his recovery illustrating the intensity and positivity of the experience. He constructed cycling exercise as a "*tonic*", having medicinal and healing qualities. The participant relates feelings of "*peace*" to physical wellbeing and exertion.

An impediment to recovery common to both groups was a sense of hopelessness, whereas common facilitators of recovery included determination, goals, hope, motivation and passion.

*“before that I didn’t have hope (.) I was lost (.) I (.) I was miserable and there wasn’t a hope for me (.)” (CE003/32-33)*

This participant describes his sense of hopelessness, lack of direction and feelings of despondency with his behaviour. His feelings suggest a lack of motivation. Many of the other participants also described their experience of feeling defeated, stuck and without hope of recovery.

*“A couple years ago I felt my life is kind of in some ruts I’m going to do a new experience every week for a year (.) And what I didn’t realise at the time (.) that was my way of actually (.) preventing myself from going back (.) to self-harm (.)” (SH001/14-15)*

Here, the participant described feeling stuck in repetition in her life and behaviour. With this awareness, she made the effort to motivate herself by experiencing new things, unconscious that this facilitated her recovery. New experiences were common as a facilitator to recovery for a couple of the participants, suggesting a need to break the pattern of repetition.

## **Action**

This theme explores the physical and psychological actions taken by both groups to enable recovery from the coping strategies of compulsive overeating and self-harm behaviour. Many of the actions described by the participants could only be employed with motivating factors such as hope and determination.



Participants with experience of compulsive overeating, revealed a need for decision making, application of rules and boundaries and a need for knowledge, met by seeking information and carrying out research.

*“I’m still learning (.) I’m (.) I’m totally still learning about what I can do (.) what I can’t do (.) what works (.) what doesn’t work (.) and I think that’s an individual journey that everyone needs to take (.) (CE008/290-292)*

In this extract, the participant describes her recovery experience from compulsive overeating as a “*learning*” process, suggesting a need for knowledge and development of awareness about herself and her behaviour. She describes establishing boundaries and rules for herself, highlighting that the experience is personal “*journey*” or process over time. Most of the participants describe a process of recovery, unique to the individual but with common features such as focus, effort, struggle, honesty, self-learning, emotional learning, meal planning, goals, self-image and learning to manage social situations.

Participants with experience of self-harm behaviour discussed the need for disclosure, in their recovery.

*“when I was at Uni I opened up within (.) probably the first fortnight (.) to my best friend all the way through Uni (.) and he was really (.) really good with it (.)” (SH004/85-86)*

Here, the participant describes her experience of trusting a friend at University, disclosing her experience of self-harm and “*opened up*”, sharing her feelings. Her language suggests she experienced acceptance and support. This experience was echoed by other participants who associated recovery with openness and sharing of feelings.

Common to both groups, were acceptance of change, power of choice, proactive effort, physical exercise, psychological fight, openness to learning, ability to plan, positive attitude,

resignation, acceptance of responsibility, establishment of routine, seeking help and support and a sense of urgency.

## **Labels**

References to diagnostic labels describing behaviour were made throughout the transcripts including addiction, drug, binge, binge eating disorder, trigger, cravings, symptoms. It became apparent that rather than being specifically diagnostic in nature, the labels referred to by both groups provided the participants with a universally acknowledged language with which to describe their experience.

*“I remember watching a documentary where they were saying that sugar is like a drug (.) It’s very addictive (.) It- It’s as addictive as cocaine (.) And (.) I realise that that is my drug (.) Sugar is my drug (.)” (CE005/11-12)*

The participant describes learning about sugar and addiction from a television documentary. Drawing on the language of addiction, she could identify with the described behaviour of addiction, providing her with socially acknowledged and accepted language to describe her experience. Negative connotations associated with this language, could however give others the perception of a lack of control and irresponsibility. The challenge of stigma also emerged within this theme, related to labels and specifically described by the participants who had experience of self-harm behaviour.

## **Honesty**

Both groups described dishonesty to themselves and others as enabling the behaviour of compulsive overeating and self-harm and practicing honesty enabling recovery and wellbeing.

*“There had been so many lies and there was so much hurt and so many of my friends were understandably so absolutely done with me (.)” (SH003/60-62)*

This participant describes an awareness of her dishonesty in her behaviour with her friends and displays empathy with their “*hurt*” and inability to support her in her behaviour. Several participants also described dishonesty with friends, partners and family often feeling regret for their behaviour.

*“I definitely found that reaching out to my family and friends this time (.) telling them when I was having an urge to do it (.) was a really big help (.)” (SH010/44-45)*

This participant describes how helpful it has been for her to be open and honest with her family and friends about her feelings and “*urges*” to self-harm, in recovery. The necessity of honesty in recovery was reflected by most participants in both groups.

Both groups frequently described denial in their experience, justifying their behaviour to themselves and others. Some participants believed they were only hurting themselves, where others did not feel that they engaged in self-harm or compulsive overeating regularly enough to fit the stereotype or the “*mould*”. A couple of participants felt they were in control of their behaviour, or could not see the harm in doing something they love, others dismissed it simply as a vice.

*“I don’t see what benefit um (.) you could have (.) you could experience by you know accepting (.) by admitting that you’re a compulsive overeater (.) um (.) I don’t know (.) Maybe that’s me being stubborn or not you know fully embracing it (.)” (CE007/71-73)*

The participant describes feeling unable to accept and relate to compulsive overeating behaviour as a problem. Through distancing himself from the label of “*compulsive overeater*”, he constructs himself as unlike others who engage in compulsive overeating, and the associated expectations of those who do compulsively overeat.

## **Awareness**

Both groups demonstrate high levels of awareness of their behaviour, and consequent emotional and psychological sensitivity which may exacerbate the need for coping strategies and support. This theme explores three sub-themes of awareness: awareness of self, awareness of others and awareness of behaviour.

### Awareness of Self

Both groups of participants displayed a high awareness of self, reflecting on their emotional, psychological and physical history with compulsive eating and self-harm.

*“the biggest thing I’ve learned in everything is that weight loss alone solves nothing (.)  
And um (.) if you’re unhappy when you’re overweight you’re going to be unhappy when  
you’re at a good weight unless you make bigger changes (.)” (CE008/268-269)*

Here, the participant describes a psychological shift within herself, gaining knowledge, “*learning*” about herself and developing an awareness of the need for change. She describes awareness of the relationship between emotion and weight and acknowledges her emotional state is independent of her physical size. This sentiment of awareness was echoed across the data and suggests that much of this has developed through self-reflection and the process of recovery. In most cases however, perplexity and desperation emerging from the behaviours themselves, created a need for self-understanding, self-reassurance and self-knowledge to survive. Unique to the participants with experience of compulsive overeating was a sense of self-reliance and the need to understand connections between the self and eating, emotion, weight and body image. Whereas, participants with experience of self-harm behaviour described awareness of need to want help and emotional development.

### Awareness of others

Both groups described awareness of the importance of connection with others, especially individuals experiencing the same behaviour. Participants with experience of self-harm

however, demonstrated a high awareness of hurting others, possibly because of the social awareness of self-harm behaviour.

*“Because there will be a point where after all of the lying they won’t know when to believe you (.) they won’t know if they want to believe you (.) and I know how hard it is to try recovery for a person other than you (.)” (SH003/51-53)*

This participant describes her experience with others, indicating her appreciation of support and realisation that dishonesty resulted in a loss of support. The participant alludes to trying to stop self-harm behaviour for other people, which was a difficult experience for her. A few participants described being dishonest with family and friends in their behaviour but this was the only example of trying to stop self-harm for others.

### Awareness of behaviour

Both groups described a level of awareness through their personal experience of patterns of behaviour, triggers and emphasis of time. Participants with experience of compulsive overeating exhibited awareness of their eating behaviour and in most cases an unhealthy relationship with food. Whereas, participants with experience of self-harm described awareness of freedom from pressure, normalising behaviour and the experience of recovery being life-saving.

*“by the time the weekend comes (.) it’s like (.) I find myself bingeing on all these foods that I call trigger foods (.) That I know that I shouldn’t have and that I know that I can’t handle like a normal person (.) but I indulge in them (.)” (CE005/17-19)*

Here, the participant describes awareness of triggers of her behaviour. This behaviour is presented as being unconscious, and automatic, and she draws on the language of addiction and pathology to explain her behaviour. In using this rhetoric she constructs herself as lacking

control over her behaviour, and is able to further distance herself from the responsibility of her actions.

## **Acceptance**

Both groups of participants described seeking and need of acceptance from others, feelings of self-blame, a lack of self-acceptance and a need for self-care and acceptance of life experiences.

*“all I wanted was acceptance (.) I was about third grade and this one kid said (.) “I can eat more pizza than you” (.) so all the kids in my class divided up their two slices of pizza between us (.) and I went through it and I heard people cheering (.) I think it was more laughter for them but acceptance for me (.)” (CE001/22-25)*

The participant describes his need for acceptance from his peers at school. His memory of trying to please the other children, is tied to food, linking the “cheering” which he interpreted as acceptance to his current feelings when he overeats. In their recovery, the participants frequently construct their process as being something they “learn[ed]”, suggesting a process of growth and gaining of knowledge about the self and others.

Participants with experience of self-harm describe being dismissed and rejected and of needing love, acknowledgement, understanding, needing to please others and learning self-acceptance through self-love.

*“I learned to grow through my experiences and I learned that my past did not define me (.) All of the struggle and the pain and the emotional hardship that I’ve experienced has really allowed me to flourish into the woman that I am today (.)” (SH007/64-67)*

The participant above, describes “grow[ing] through” her personal experiences, suggesting a processing, feeling and acceptance of the events in her life. She implies discovery of herself

and her identity. Her language suggests she has endured a difficult emotional process leading to an emergence of acceptance of herself. Several participants echoed this experience of growth and recovery, describing a process of self-acceptance and discovery.

### **Accomplishment**

The sense of accomplishment described by participants with experience of compulsive overeating behaviour was described as a solution, life changing and surviving rather than recovery. Whereas, participants with experience of self-harm behaviour described a process of achievement, recovery and relapse. Both groups described recovery as a journey of progress and realisation.

*“I feel like a lot of people identify with food problems and I think there’s a lot of different solutions to it and I think you have to find the one that (.) that works for you (.) And I’ve learned a lot and I’ve come really far (.) That’s not to say that I’m anywhere close to the destination of where I want to be forever (.) but um (.) but I’m working on it and I’m getting better” (CE008/301-304)*

Here, the participant implies she no longer feels alone with compulsive overeating and that there is no single solution to finding recovery. She along with many of the other participants suggests that recovery is a personal journey of learning, illustrating that progress is as important for a sense of accomplishment and self-worth, as complete recovery.

*“If you don’t learn to become your own person you’re never going to learn how to prosper (.) If you live your life each and every day striving to conform to society or those around you (.) you’re never gonna meet your own happiness (.) And I guess you can say I learned that the hard way (.) But here I am happy (.) thriving (.) and loving the life that I am living all because I simply found myself (.)” (SH007/70-74)*

The participant emphasises self-learning, suggesting her experience has shown her that pressure to conform to “society” and other people only exacerbates self-harm behaviour. There is a clear association between self-acceptance and understanding, peace, love of life and recovery. This and many of the participants experience illustrates a strong focus on the self in recovery, rather than others.

## **Summary**

In summary, there is considerable similarity and overlap of experience between those with compulsive overeating and self-harm behaviour. Both groups described an awareness and lack of acceptance for body-image and body-consciousness, implying a connection between the psychological processes and the behaviours. A conscious awareness of the behaviours as a coping strategy, as well as a conscious need for alternative and positive coping strategies and support, was common to both groups.

The analysis revealed an emotional and body focused response to life events, emotional variability reflected in disordered eating patterns and an association between emotional and physical wellbeing, ‘filling’ emotional emptiness with food for participants with experience of compulsive overeating. These participants also presented with a need to belong and connect with other people who can relate and understand their behaviour and their measure of self-worth is externally focused. They also raised the need for boundaries, information and decision making in the recovery process.

Participants with experience of self-harm described difficulty understanding and managing their emotions in response to life events. The onset of self-harm behaviour during adolescence was highlighted due to intrapersonal and interpersonal challenges. The participants also described a need to feel a part of something, rather than a specific group of people. Analysis of emotional wellbeing suggests unresolved anger, anxiety and panic attacks is prevalent with this behaviour. Participant experience suggests a turning inwards of anger



and blame with behaviour feeling out of control. Despite, raised concern of stigma, the participants acknowledged a need for openness and disclosure in the process of recovery.

(8,383)

## Discussion

Self-harm and compulsive overeating are innately secretive behaviours (Adams, Rodham, & Gavin, 2005) as talking about the behaviour and underlying reasons for the behaviour can be challenging, shaming and exposing. Both behaviours appear to be proactive coping strategies to manage emotional distress although currently, an in-depth understanding of the personal experiences and feelings of self-harm behaviour are limited and compulsive overeating behaviour is frequently misaligned with BED, impeding progress of its recognition as a unique and separate behaviour. This study set out to explore the understandings of those who self-harm and compulsively overeat, using a qualitative approach. The research question was: *How do those who have compulsive overeating behaviour differ from those who self-harm?*

### Summary of themes

In this study, a six-stage qualitative Thematic Analysis (Braun & Clarke, 2006) of twenty YouTube videos of compulsive overeating and self-harm personal experience was conducted. The theme of *life experience* explored the shaping and development of the participant's emotional and psychological response to life events as well as the predisposition for self-harm or compulsive overeating behaviour. The theme of *emotional wellbeing* explored how the participants feel about themselves, others and the behaviour of self-harm and compulsive overeating. *Belonging*, highlights the psychological and emotional need of the participants to have connection with and feel a part of larger society. *Support* emphasises the participant's need for support as well as support with the behaviour of self-harm and compulsive overeating. *Self-esteem* offers insight into the participant's sense of being and self-worth. *Shame* encapsulates the emotional and psychological entrapment of the participants within their behaviour and their feelings about themselves. *Isolation* describes the emotional, psychological and physical state of being, through both choice and necessity. *Control* emerged as a way for the participants to manage emotional wellbeing in isolation. *Coping strategies* offers deeper insight into how self-harm and compulsive overeating behaviour perform as coping strategies and the need for healthy alternative coping strategies. *Behaviour*

offers further understanding of the psychological and physical behaviour of self-harm and compulsive overeating. *Consequences* captures the participants emotional, psychological and physical experiences, resulting from their own and others behaviour. *Motivation* defines the emotional and psychological underlying drive for change. *Action* emphasises the need for individual accountability of the participant's actions and for their recovery. *Labels* emerged from the extensive reference and use of labels throughout to describe personal experience. *Honesty* relates to honesty with self, others and behaviour, highlighted as being a barrier or gateway to recovery. *Awareness* explores awareness of self, others and behaviour, revealing a high level of awareness in both groups of participants. *Acceptance* encapsulates the participant's self-acceptance, need for acceptance, acceptance of others and acceptance of behaviour. *Accomplishment*, explores the participants sense of wellbeing through experiencing the recovery process.

Analysis of the above themes offers deeper insight into the experiences of participants with compulsive overeating and self-harm behaviour, and how these differ. The following section reviews these themes considering existing literature and research.

### Characteristics of compulsive overeating behaviour

Behavioural characteristics of compulsive overeating were shown to be prevalent across the lifespan, with participants illustrating frequent onset of behaviour from a young age. Early memories and childhood experiences contributory to emotional underdevelopment and the need for familial support and validation were important in the participants' stories, supporting previous studies (Fairburn et al., 1997; Hilbert et al., 2014; Micali et al., 2017). Compulsive overeating was shown to be isolating for the participants due to the nature of secrecy and need to hide the behaviour from friends and family, attributed to intrapersonal conflict and fear of anger and conflict with others. Micali et al.'s (2017) paper supports these findings, highlighting interpersonal sensitivity; a sensitivity to and fear of reaction from others characterised by underdeveloped interpersonal skills and feelings of inadequacy, as a common underlying cause of all eating disorders.

Compulsive overeating is often aligned with BED due to the diagnostic similarity to BN and the criterion of “being unable to control eating large quantities of food mindlessly” (American Psychiatric Association, 2013). The analysis in this study identified that in addition to quantity, speed and frequency of overeating, are key characteristics of compulsive overeating. This differentiates the behaviour of compulsive overeating from BED and BN criterion. Many participants in the study described variable and boundaryless behaviours, contrary to being limited to a ‘discrete period of time’ (American Psychiatric Association, 2013). The analysis shows, compulsive overeating is behaviourally repetitive, occurring on a spectrum of severity, often unremitting despite described conscious awareness of the behaviour by the participants.

The participants also described dishonesty with themselves and others, manifesting in deceptive behaviours to avoid exposure. Participants, drew upon the language of addiction in their stories, echoing previous assertions of compulsive overeating behaviour, feeling like an addiction to food (National Centre for Eating disorder, 2012). Davis and Carter (2009) described compulsive overeating behaviour in terms of substance and behavioural addiction, an idea supported by the participants described need and experiences for specific foods, commonly sugar and fat, as well as behaviours of secrecy, quantity and release.

This study also draws attention to several emotional and psychological characteristics and experiences attributed with compulsive overeating preferences. In the moments preceding compulsive overeating or self-harm behaviour, participants reported experiencing hyper-emotional sensitivity, excitement and anticipation. During and following the behaviours, reports of euphoria and a sense of relief followed by self-blame, concern with the impact on others and intrapersonal processes of denial, emerged in the participants experience, illustrating a cycle of behaviour also identified within Grant and Boersma’s (2005) hermeneutic analysis. The DSM-5 (American Psychiatric Association, 2013) describes binge eating as an action induced by an overwhelming emotion, event or situation (American Psychiatric Association, 2013, p.346). This study supports this criterion and overlap with binge eating

disorder, with participants describing overwhelming emotion such as depression, grief, shock, stress and trauma, as being 'triggers' for compulsive overeating.

Heatherton and Baumeister (1991) presented 'escape theory' describing an alleviation of negative affect and escape from self-awareness through binge eating. The findings of this study support this concept with participants describing compulsive overeating as a means of escape from emotional pressure and feelings of lack of emotional support and control around life events. Patching and Lawler's (2008) study and Micali et al.'s (2017) study support lack of control as contributory to eating disorders.

The results of the analysis suggest a lack of ability to make healthy food choices, exacerbates compulsive overeating behaviour. However, low self-esteem, a critical inner voice and the need for validation and acceptance, illustrated in the participant's experience, underlie the need for this behaviour. The results support compulsive overeating behaviour as a conscious coping strategy to establish control over feelings of shame, loneliness and low self-esteem, although, supported by past studies (Rørtveit, Åström and Severinsson, 2009; Nevonen and Broberg, 2000), the same behaviour also stimulates feelings of shame, remorse and a need for secrecy as well as induces a fear of judgement and humiliation from others.

The findings of this study suggest that compulsive overeating is a progressive behaviour that becomes internalised as compulsion and obsession, supported by Davis (2013) and Wardle (1987). Filbey, Myers and DeWitt (2012) also support the idea of compulsion and obsession in their definition of compulsive eating as a psychological obsession with food, body image and weight in addition to a physical compulsion to consume or 'use' food as a coping mechanism.

Throughout the analysis, high levels of self-awareness were observed in the participant's experience, developed through intense self-reflection and the recovery process. These

findings along with findings from Pereira, Quinn and Morales (2016) study highlight and support that YouTube videos themselves encourage introspection.

### Characteristics of Self-Harm behaviour

Through the analysis, participants with self-harm experience identified self-harm behaviour as a strategy to manage and cope with feelings that are not easily understood and talked about. The participants open sharing of their experience however, through the YouTube platform implies a level of comfort and distance from others, supported by Chenail, (2011) and Giglietto, Rossi and Bennato's (2012) work, stating YouTube as a significant and unique data resource in which individuals are able "to express themselves in ways that may be constrained in their real-world interactions" (Rodham and Gavin 2006, p.95).

Most participants used language of addiction such as "addiction" and "trigger" to describe their experience although it was noted that none of the participants labelled themselves as "self-harmers", suggesting that whilst many people welcome and find labels useful to describe experience in a socially accepted language, there is also an element of demoralisation, generalisation and stigma associated with them, thereby supporting the person-first approach (Buckingham & Best, 2017; Braun & Clarke, 2006).

The participants described a behavioural cycle of low self-esteem and self-harm behaviour, with some participants alluding to an element of punishment in their behaviour and most participants displaying self-deprecating behaviour; Rodham, Hawton and Evans' (2004) paper also presented findings of punishment in self-harm. Participants talked about their need for secrecy, a characteristic supported by Hawton & James' (2005) paper, and a prevalence of self-harming 'urges' at night-time, illustrating their behaviour as ritualistic in nature with a sense of momentum and escalation in frequency. Most of the participants alluded to the behaviour being repetitive and destructive across a spectrum of severity. Hawton et al.'s (2002) definition of self-harming behaviour supports this, describing self-harm as 'an act with a non-fatal

outcome', inflicted with wounds to self or behaviour of self-poisoning or overdose. Horner (2016) also comments also on the repetitive nature of self-harm.

The participant's lack of self-acceptance and ability to understand and process their emotions, was often presented as self-deprecating due to a sense of inadequacy and blaming themselves for their own and others behaviour. These findings mirror those of Adams, Rodham and Gavin's (2005) phenomenological analysis of deliberate self-harm and the intrinsic self, described as being "distinctly negative (in) tone in terms of self-judgements" (Adams, Rodham & Gavin, 2005, p.1300).

Lack of familial and/or peer support in early childhood experiences was described by the participants, supported by Skegg (2003, 2010) and Klonsky, Oltmanns & Turkheimer's (2003) papers highlighting childhood trauma and interpersonal difficulty as increased risk factors for self-harm behaviour. Findings from this analysis also highlighted emotional intolerance, emotional underdevelopment and emotional sensitivity as underlying the motivation and function of self-harm behaviour. Participants emphasised the need to reduce feelings of pressure, lack of control, insecurity, overwhelm, depression and anxiety, supported in past studies with the frequent association of self-harm behaviour with depression and anxiety disorders (Klonsky, Oltmanns & Turkheimer, 2003; Skegg, 2010; Wester & Trepal, 2017).

The participants also reported a sense of shame, embarrassment and guilt, specifically relating to dishonesty with family and friends and risk of exposure and vulnerability. Skegg (2005) also identified psychological consequences of shame, guilt, isolation, stress, low self-esteem and depression relating to self-harm behaviour. Self-harm behaviour was considered by the participants to be a coping strategy to manage and reduce emotional intolerance and sensitivity. This echoes Chapman et al.'s (2005) experiential avoidance model as participants described an internalisation of the need to self-harm, manifesting as obsessional thoughts and 'urges' or compulsion to self-harm.

Several characteristics were highlighted through the participant's experience of recovery from self-harm behaviour such as self-learning, growth, self-acceptance, compassion, honesty, hope and offering support to others. A need for disclosure and openness was considered key to combat the behaviour of secrecy and concealment. Physical exercise and new experiences were also contributory to the recovery process. Emphasis on the need for emotional and physical support in the recovery process from self-harm behaviour emerged from the participant's experience. Support networks such as YouTube provide a sense of and access to community support and reinforcement although they can also affect positive and negative normalisation (Madge et al., 2008; Lewis et al. 2011).

#### Considering the overlap and differences

There is a clear overlap between self-harm and compulsive overeating with both groups notably describing their awareness and lack of acceptance of body-image and body consciousness, related to their behaviour. These findings parallel conclusions drawn in existing studies exploring the comorbidity of eating disorders and self-harm (Claes et al., 2011; Favazza et al., 1989; Kerr et al., 2010; Muehlenkamp et al., 2009; Paul et al., 2002; Solano et al., 2005; Taliaferro and Muehlenkamp, 2015). Both groups also illustrated a conscious awareness of the use of this behaviour as a coping strategy to manage low self-esteem, emotional distress and emotional overwhelm, supported by Skegg (2015)

Key areas of difference also emerged between the participants. Compulsive overeating behaviour was revealed as being prevalent across the lifespan with more reported instances of the onset of the behaviour at a young age. Nederkoorn et al. (2015) identified overeating in young children but attribute this to impulsivity. Self-harm behaviour however, is most prevalent during adolescence due to intrapersonal and interpersonal pressures and challenges, supported by past studies ((Hornor, 2016; Hawton, Saunders & O'Connor, 2012; Skegg, 2003; Skegg, 2010; Sinclair & Green, 2005).



Participants with compulsive overeating experience also described a more emotional and body focused response to key life events whereas participants with self-harm experience, presented with difficulty understanding and managing emotions, supported by Gratz and Roemer's (2007) findings, thereby creating a need for control. Emotional variability was evident in both groups of participants; however, the relationship between emotional and behavioural variability and was only evident in the disordered eating patterns of compulsive overeating behaviour. Kent, Waller and Dagnan (1999) also explored the connection between emotions and disordered eating in adulthood, although the focus of their research was limited to emotional abuse. The findings in this study revealed a clear association between emotion and food and emotion and physical wellbeing for the participants with compulsive overeating experience, namely the action of filling emotional emptiness with food. The participants with experience of self-harm behaviour however described emotional experience of unresolved anger and high levels of anxiety, evidenced by a higher reported instances of panic attacks and turning inwards of anger and blame. Crouch and Wright's (2004) phenomenological analysis, supports this, showing self-harm behaviour as being directly associated with feelings of anger directed towards the self, others and the environment.

Both groups of participants also described the need to belong, although participants with compulsive overeating experience sought to connect with others who could relate and understand their behaviour. Troisi and Gabriel (2011) explore the relationship with food and need to belong in terms of food being a comfort associate with relationship. In contrast, participants with self-harm behaviour were driven less toward relationship and more towards feeling a part of greater society. Another key difference between the participants is the focus of their self-esteem and self-worth, whether their self-worth is maintained and developed based on external or internal influences, their locus of evaluation. Participants with compulsive overeating behaviour describe an external locus of evaluation, whereas participants with self-harm behaviour present an internal locus of evaluation. The participants frequently allude to feelings of lack of control although participants with compulsive overeating refer to life feeling

out of control and participants with self-harm behaviour refer to their behaviour feeling out of control. Differences emerged in the recovery process of both behaviours with compulsive overeating presenting a need for boundaries, information and decision making in the recovery process and self-harm requiring self-disclosure and openness from the participants despite concerns about stigma.

### Directions for future research

Research to date has focused predominantly on recognised eating disorders such as AN, BN and BED developing understanding and definition of these behaviours (Giannini, Newman & Gold, 1990; Garfinkel & Modofsky, 1980; Vitousek & Manke, 1994; and Stice, Telch & Rizvi, 2000). Research pertaining to compulsive overeating behaviour is in its infancy but is beginning to be defined, differentiated from BN and BED (Davis & Carter, 2009; Wardle, 1987; Filbey, Myers & DeWitt, 2012). This study has highlighted several areas that would benefit from further research and deeper insight, such as investigation into the lifespan prevalence of compulsive overeating behaviour. It would also be useful to investigate the recovery process and the importance of community in recovery, as well as recovery success rates for self-harm and compulsive overeating behaviour. The considerable similarity and overlap between the behaviours also suggests further investigation is needed, exploring the co-morbidity of self-harm and compulsive eating as well as the concept of compulsive overeating behaviour being used as a form of self-harm.

### Strengths & Limitations

A strength of this study was methodology of qualitative Thematic Analysis, applying Braun and Clarke's (2006) six stages of analysis. Thematic analysis offers a methodologically flexible, in depth and sensitive approach to exploring the intrapersonal and interpersonal experience of the participants. The study also utilised YouTube videos as a data source (YouTube.com), enabling access to undirected, open disclosure of the participant's personal experience, whilst maintaining anonymity and the safety of the participants. The focus of this study was to explore the experiences of those recovering from self-harm or compulsive overeating.

Consequently, we have gained an insight into retrospective accounts of their experiences with the behaviours. What is less clear, however is how people who are currently engaging in self-harm or compulsive overeating behaviours make sense of their experiences.

### Reflections on social constructionism & relativism

Approaching this research from a relativist ontological perspective, analysis of the participants experience sought to understand how the participant established meaning and truth from their experience, whilst acknowledging that interpretation of the participants experience was based on the researchers own evolution of truth. The epistemological social constructionist approach of the research impacts the analysis and resulting identification and definition of themes, as developing an understanding of the truth and what and how that truth is defined, is constructed on the researchers reaction to the participants described experience in addition to the researchers own experience.

### Summary

In summary, the findings of this study support compulsive overeating behaviour as a secretive, isolating and progressive behaviour of obsession and compulsion with prevalent onset at an early age. Compulsive overeating behaviour is variable, occurs on a spectrum of severity and is not confined by quantity, speed or frequency of overeating. Compulsive overeating is a coping strategy employed to manage overwhelming emotion and distress, manifesting into a cycle of emotional shame and escalating behaviour. The findings of this study support past studies and existing research on self-harm behaviour but highlight considerable similarity of emotional, psychological and behavioural characteristics with compulsive overeating behaviour. Although differences between compulsive overeating and self-harm behaviour were identified, the considerable similarity between the behaviours warrants further investigation to explore co-morbidity of the behaviours further in addition to the conceivability of compulsive overeating behaviour being used as a form of self-harm.

## Conclusion

In conclusion, the objectives of this research were to gain a deeper insight and understanding of the intrapersonal and interpersonal, innately secretive behaviours of self-harm (Adams, Rodham, & Gavin, 2005) and the relatively unknown and officially unrecognised behaviour of compulsive overeating. The aim of the study was to complete a comprehensive analysis of the personal experience of participants through the platform of YouTube (YouTube.com), using qualitative Thematic Analysis (Braun & Clarke, 2006) methodology to explore the fundamental emotions, thoughts and processes of compulsive overeating and self-harm behaviour. The research question directing the analysis was: *How do those who have compulsive overeating behaviour differ from those who self-harm?*

The analysis revealed 18 themes relating to the participants psychological, emotional and behavioural experience of compulsive overeating and self-harm offering insight into similarities and differences between the participants experience of both behaviours. Substantial commonality between the participants experience of compulsive overeating and self-harm behaviour was identified, most notably the awareness of lack of acceptance of body-image and body-consciousness in both groups and the conscious awareness of the use of compulsive overeating and self-harm as a coping strategy to manage and avoid emotional distress, overwhelm and intrapersonal conflict.

Key differences between both behaviours were also identified, pertaining to the research question, including: a difference in the age of onset of behaviour, the emotional and bodily focused response to life events by participants with compulsive overeating experience, as opposed to difficulty understanding and managing emotions, thereby creating a need for control for the participants with self-harm experience. Participants with experience of compulsive overeating also expressed awareness of a relationship between emotion, food and physical wellbeing whereas participants with experience of self-harm behaviour expressed awareness of a turning inwards of emotion. The participants also described a need to belong

with a focus on the need for relationship expressed by participants with experience of compulsive overeating and participants with experience of self-harm describing a need to feel part of society. Differences were also apparent in the formation and maintenance of self-esteem. Participants with compulsive overeating behaviour develop self-esteem from external feedback whereas participants with self-harm behaviour self-generate and internally diminish self-esteem. Finally differences in the participants description of needs in recovery was found to differ, with participants with self-harm experience describing a need for self-disclosure and openness whereas, participants with compulsive overeating described a need for boundaries, information and decision making.

Key findings for this study were the considerable similarity in psychological, emotional and behavioural processes of compulsive overeating and self-harm behaviour. These findings suggest that further research is required to further understanding of compulsive overeating behaviour as a separate disorder as well as to aid in the prevention and treatment of compulsive overeating and in terms of the plausibility of compulsive overeating being considered a form of self-harm. Continued qualitative research and understanding of intrapersonal and interpersonal processes of self-harm behaviour is essential to further develop effective prevention and treatment of self-harming, predominantly in adolescents.

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## **Appendices**

### **APPENDIX A**

#### **ETHICS APPLICATION FORM**

Staff / Office Use Only

DOPEC NUMBER: \_\_\_\_\_

Umbrella project DOPEC number (staff) \_\_\_\_\_

AIP

APPLICANT SURNAME: WYATT

Please complete all questions by underlining the correct response to facilitate correct processing

APPLICANT:                      UG                      PGT                      PGR                      STAFF

REVIEW PROCESS:              Accelerated / Full

APPLICATION STATUS:        NEW APPLICATION, MAJOR AMENDMENT, RESUBMISSION

APPLICATION FOR:              DISSERTATION, TEACHING, RESEARCH & PUBLICATION

ATTENDENCE AT HEALTH & SAFETY BRIEFING:    YES / NO / NA

INCLUSION OF RISK ASSESSMENT FORM:           YES / NO / NA

**NOTES ON THE ROLE AND FUNCTION OF THE DEPARTMENT OF PSYCHOLOGY ETHICS COMMITTEE.**

- All decisions of the committee are based on the application form and reviewers comments ONLY. Forms should be as detailed and clear as possible. Verbal discussions are not considered as part of the application or review process.
- The review process strictly adheres to the University of Chester Research Governance Handbook and the BPS Code of Ethics.
- The decision of the committee is final. If you are a UG, PGT or PGR student you should discuss the decision of the committee with your supervisor. If you are a member of staff you may contact the chair of the committee for further clarification.

Before completing the form researchers are expected to familiarise themselves with the regulatory codes and codes of conduct and ethics relevant to their areas of research, including those of relevant professional organisations and ensure that research which they propose is designed to comply with such codes.

Department of Psychology Ethical Approval for Research: Procedural Guidelines.

University of Chester Research Governance Handbook

[http://ganymede2.chester.ac.uk/view.php?title\\_id=522471](http://ganymede2.chester.ac.uk/view.php?title_id=522471)

BPS Code of Ethics

[http://www.bps.org.uk/system/files/Public%20files/bps\\_code\\_of\\_ethics\\_2009.pdf](http://www.bps.org.uk/system/files/Public%20files/bps_code_of_ethics_2009.pdf)

BPS Code of Human Research Ethics

[http://www.bps.org.uk/sites/default/files/documents/code\\_of\\_human\\_research\\_ethics.pdf](http://www.bps.org.uk/sites/default/files/documents/code_of_human_research_ethics.pdf)

BPS Guidelines for Internet-mediated Research

<http://www.bps.org.uk/system/files/Public%20files/inf206-guidelines-for-internet-mediated-research.pdf>

BPS Research Guidelines and Policy Documents

<http://www.bps.org.uk/publications/policy-and-guidelines/research-guidelines-policy-documents/research-guidelines-poli>

Any queries email: [psychology\\_ethics@chester.ac.uk](mailto:psychology_ethics@chester.ac.uk)

### CHECK LIST.

Please complete the form below indicating attached materials. Prior to submission supervisors must confirm that they have reviewed the application by completing the supervisors column.

<i>Notes: Students to indicate where information is found, supervisor to confirm by ticking green column</i>	<u>Supervisor confirmation</u>	<u>Information sheet</u>	<u>Letter</u>	<u>Email</u>	<u>Email info. page</u>	<u>Consent Form</u>	<u>PowerPoint</u>	<u>N/A</u>
Brief details about the purpose of the study	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Contact details for further information	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Explanation of how and why participant has been chosen	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Notification that materials/interviews are not diagnostic tools/therapy or used for staff review/development purposes	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Explanation participation is voluntary	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Details of any incentives or compensation	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Details of how consent will be obtained	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
If research is observational, consent to being observed	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Details of procedure so participants are informed about what to expect	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Details of time commitments expected	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Details of any stimuli used	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Explanation of right to withdraw and right to withdraw procedure	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Option for omitting questions participant does not wish to answer	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Procedure regarding partially completed questionnaires or interviews	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
With interviews, information regarding time limit for withdrawal	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Details of any advantages and benefits of taking part	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Details of any disadvantages and risks of taking part	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Information that data will be treated with full confidentiality and that, if published, those data will not be identifiable as theirs	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Debriefing details	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Dissemination information	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Further information (relevant literature; support networks etc)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

**Supervisor Signature: Hannah Heath**

**Date: 31.01.17**



DEPARTMENT OF PSYCHOLOGY  
APPLICATION TO DEPARTMENTAL  
ETHICS COMMITTEE



University of  
Chester

**IN COMPLETING THE FORM UG & PGT STUDENTS PLEASE REFER TO YOUR  
HANDBOOK**

**Question 1: Working title of the study**

*Notes: The title should be a single sentence*

The relationship between compulsive overeating behaviour and self-harm: An analysis of YouTube videos.

**Question 2: Applicant, name and contact details.**

*Notes: The primary applicant is the name of the person who has overall responsibility for the study. Include their appointment or position held and their qualifications. For studies where students and/or research assistants will undertake the research, the primary applicant is the student (UG, PGT, PGR) and supervisor is the co-applicant.*

Claire Wyatt BSc (Hons)  
[1621416@chester.ac.uk](mailto:1621416@chester.ac.uk)

**Question 3: Co-applicants**

*Notes: List the names of all researchers involved in the study. Include their appointment or position held and their qualifications.*

Dr Hannah Heath BSc, MSc, PhD  
Supervisor  
[h.heath@chester.ac.uk](mailto:h.heath@chester.ac.uk)

**Question 4: What are the start and end dates of the study?**

*Notes: If exact dates are unavailable, explain why and give approximate dates.*

February 2017 (subject to ethics committee approval) – 1 September 2017

Contingency Plan – In the event of low availability of YouTube resources that meet inclusion/exclusion criteria, search terms will be broadened or added to, which would be submitted in an amendment form.



**Question 5: Is this project subject to external funding?**

*Notes: Please provide details of the funding body, grant application and PI.*

No

**Question 6: Briefly describe the purpose and rationale of the research**

*Notes: In writing the rationale make sure that the research proposed is grounded in relevant literature, and the hypotheses emerge from recent research and are logically structured.*

*PGR / Staff if this application is for a funded project please attach any detailed research proposals as appropriate.*

*Maximum word length (300 words)*

Compulsive overeating is a behaviour often grouped and defined with Binge Eating Disorder. Binge Eating Disorder is recognised as similar in diagnostic features to Bulimia Nervosa, where a person is unable to control eating large quantities of food mindlessly or in a 'discrete period of time' (DSM V). Unlike Bulimia however, Binge eaters do not purge their food and therefore often have difficulty controlling or maintaining a healthy body weight. Compulsive overeating is not currently recognised as an eating disorder differentiated from binge eating disorder, but rather a behaviour that describes 'eating patterns that feel out of control and which can feel like an addiction to food' (National Centre for Eating disorders). Whilst many of the traits of compulsive overeating and binge eating behaviour overlap (Davis 2013), the key differences between binge eating and compulsive overeating are, binge eating is an action 'triggered' by an overwhelming emotion, event or situation, diagnostically determined to last 'usually less than 2 hours' (DSM V) whereas compulsive overeating behaviour, similar to addiction (Davis and Carter 2009, Davis 2013), is a psychological obsession with food, body image and weight in addition to a physical compulsion to consume or 'use' food as a coping mechanism and is not confined by time or quantity parameters. For the purposes of this research, the search parameters for personal experience will be limited to compulsive overeating behaviour experience.

Self-harming behaviour has been comprehensively defined as 'an act with a non-fatal outcome' (Hawton et al 2002) inflicted with wounds to self or behaviour of self-poisoning or overdose. This behaviour acts as a coping mechanism to manage, by way of reducing or releasing, overwhelming emotion and interpersonal anxiety.

Research shows that people who self-harm often also suffer with an eating disorder and vice versa, people who have an eating disorder are also often associated with higher rates and risk of self-harming behaviour (Favazza et al., 1989, Kerr et al., 2010, Paul et al., 2002, Claes et al., 2011). For the purposes of this research, the search parameters for self-harming behaviour will be limited to verbal experience from individuals in recovery from self-harm.

Due to the secretive nature of self-harm (Adams, Rodham, & Gavin, 2005) and the relatively under-identified compulsive overeating behaviour, YouTube presents itself as a useful opportunity to explore understandings. YouTube is a video sharing platform that was created in 2005, providing free video streaming for more than a billion users (YouTube.com) to upload and edit videos, make comments on videos, and create playlists. YouTube is a significant resource in which individuals are able 'to express themselves in ways that may be constrained in their real-world interactions' (Rodham and Gavin 2006:95).

The aim of this research is to gain a greater understanding and insight, through exploring YouTube personal experiences, of self-harming behaviour and compulsive overeating. The research question is: How do those who have compulsive overeating behaviour differ from those who self-harm?

**Question 7: Describe the methods and procedures of the study**

*Notes: Attach any relevant material (questionnaires, supporting information etc.) as appendices and summarise them briefly here (e.g. Cognitive Failures Questionnaire: a standardised self-report measure on the frequency of everyday cognitive slips). Do not merely list the names of measures and/or their acronyms. Include information about any interventions, interview schedules, duration, order and frequency of assessments. It should be clear exactly what will happen to participants. If this is a media based study describe and list materials include links and sampling procedure. (500 words)*

Study overview

This study will be a Thematic Analysis of 30 YouTube videos of people talking about their experiences of compulsive overeating behaviour (15), and their experiences of self-harm (15).

Sample source & size

30 YouTube videos consisting of 15 personal experiences of compulsive overeating behaviour and 15 personal experiences of self-harm behaviour will be sampled. This sample size stands in line with previous qualitative studies that have used around 30 YouTube videos (Gao et al., 2013; Chou et al., 2011; McDaniel, 2014; Lewis et al., 2010).

Search criteria

Search criteria for the YouTube videos comprises: 'compulsive overeating story', 'overeating story', 'compulsive overeating', 'overeating', 'compulsive food addiction story', 'self-harm recovery story', 'self-injury recovery story', 'recovery from self-harm'.

Inclusion & Exclusion criteria

Inclusion criteria for the videos includes: First person verbal account of experience, information describing feelings, thoughts, emotions, triggers, behaviour and recovery, individual appearance and content of video is indicative of age 18+, all genders, English speaking, good quality audio.

Exclusion criteria for the videos includes: Advertisements, videos related to Anorexia Nervosa or Bulimia Nervosa, Treatment centres, weight loss solutions, videos with only images, videos where individual appearance or content suggests age is under 18, videos that suggest individuals are currently self-harming, videos exceeding 1 hour in length, videos containing graphic material or suicidal content.

Analysis

The final 30 selected YouTube videos will be transcribed verbatim (all identifying information e.g. Names/locations will be anonymised). The videos will be analysed using Braun and Clarke's (2006) six stages of Thematic Analysis comprising; a familiarisation and engaging with the data collected, coding the data and collating the codes to capture the semantic and conceptual tones of the data relative to the research question, engaging in a search for themes that emerge from the coding process, reviewing the themes against the coded data and the full data set seeking relationships between the themes and defining and naming the themes in detail.

Focus will be paid to comparing similarities, dissimilarities and overlap of concepts between compulsive overeating and self-harm behaviour.

**Question 8: Has the person carrying out the study had previous experience of the procedures? If not, who will supervise that person?**

*Notes: Say who will be undertaking the procedures involved and what training and/or experience they have. If supervision is necessary, indicate who will provide it.*

My professional experience with clients will help to inform my analysis of the participant's recordings. I have also worked with qualitative Content Analysis in the MSc Psychology (Conversion) and I will be supported by Dr Hannah Heath to implement Braun & Clarke's (2006) six stages of analysis for this study.

**Question 9: What ethical issues does this study raise and what measures have been taken to address them?**

*Notes: Describe any discomfort or inconvenience that participants may experience. Include information about procedures that for some people could be physically stressful or might impact on the safety of participants, e.g. interviews, probing questions, noise levels, visual stimuli, equipment; or that for some people could be psychologically stressful, e.g. mood induction procedures, tasks with high failure rate. Discuss any issues of anonymity and confidentiality as they relate to your study, refer to ethics handbook and guidance notes at the end of the form. If animal based include ethical issues relating to observation.*

There are a few ethical considerations with using YouTube material. These are: 1) reduced risk of harm to vulnerable individuals, 2) material available in the public domain and 3) implementing full anonymization of the research data to ensure confidentiality.

1) As YouTube uploading is open to those aged 13 and above, efforts will be made to ensure that videos of those under the age of 18 are not sampled. This will be identified through visible appearance, and discussion that suggests age below the age of 18 (i.e. current college/school experiences)

2) Per the BPS Guidelines for ethical practice in psychological research online (2013), observation of public behaviour needs to take place only where people would 'reasonably expect to be observed by strangers' (British Psychological Society 2009, p.13). Content on YouTube is freely and publicly accessible, and as such consent is assumed.

3) In order to ensure confidentiality, all transcribed recordings will be anonymised to protect the identity of the participants. All names/locations or identifying factors in the recordings will be replaced using pseudonyms (British Psychological Society, 2013, Rodham & Gavin 2006).

**Question 10: Who will the participants be?**

*Notes: Describe the groups of participants that will be recruited and the principal eligibility criteria and ineligibility criteria. Make clear how many participants you plan to recruit into the study in total.*



The sample will include:

- Individuals who have voluntarily uploaded their experience of Compulsive overeating behaviour to YouTube
- Individuals who have voluntarily uploaded their experience of self-harm behaviour to YouTube
- Individuals in recovery from self-harm behaviour
- Varied in age, sex and race (subject to availability and language of recordings)
- English speaking
- Individuals will be 18+ years old (as determined by appearance and content of recordings)
- Recordings will be selected per inclusion and exclusion criteria as follows:
- *Inclusion criteria* for the videos includes: First person verbal account of experience, information describing feelings, thoughts, emotions, triggers, behaviour and recovery, individual appearance and content of video is indicative of age 18+, all genders, English speaking, good quality audio.
- *Exclusion criteria* for the videos includes: Advertisements, videos related to Anorexia Nervosa or Bulimia Nervosa, Treatment centres, weight loss solutions, videos with only images, videos where individual appearance or content suggests age is under 18, videos that suggest individuals are currently self-harming, videos exceeding 1 hour in length, videos containing graphic material or suicidal content.

#### Question 11: Describe participant recruitment procedures for the study

*Notes: Gives details of how potential participants will be identified or recruited. Include all advertising materials (social media messages, posters, emails, letters, verbal script etc.) as appendices and refer to them as appropriate. Describe any screening examinations. If it serves to explain the procedures better, include as an appendix a flow chart and refer to it.*

30 videos will be used in the sample, 15 exploring the experiences of those who compulsively overeat, 15 exploring the experiences of those who self-harm. Videos will be identified based on an opportunistic sampling method of videos which meet the inclusion and exclusion requirements.

Search criteria for the YouTube videos comprises: 'compulsive overeating story', 'overeating story', 'compulsive overeating', 'overeating', 'compulsive food addiction story', 'self-harm recovery story', 'self-injury recovery story', 'recovery from self-harm'.

#### Question 12: Describe the procedures to obtain informed consent

*Notes: Describe when consent will be obtained. If consent is from **adult participants**, give details of who will take consent and how it will be done. If you plan to seek informed consent from **vulnerable groups** (e.g. people with learning difficulties, victims of crime), say how you will ensure that consent is voluntary and fully informed.*

*If you are recruiting **children or young adults** (aged under 18 years) specify the age-range of participants and describe the arrangements for seeking informed consent from a person with parental responsibility. If you intend to provide children under 16 with information about the study and seek agreement, outline how this process will vary according to their age and level of understanding.*

*How long will you allow potential participants to decide whether or not to take part? What arrangements have been made for people who might not adequately understand verbal explanations or written information given in English, or who have special communication needs?*

*If you are not obtaining consent, explain why not.*

Informed consent cannot be gained. Instead, consent is assumed due to the publicly accessible nature of YouTube (BPS, 2013).

The transcribed recordings will be anonymised to protect the identity of the participants. All names/locations or identifying factors in the recordings will be replaced using pseudonyms and quotes from transcriptions will be paraphrased to prevent traceability through search engines (British Psychological Society 2013; Rodham and Gavin 2006).

**Question 13: Will consent be written?**

Yes/**No** (delete as appropriate)

*Notes: If yes, include a consent form as an appendix. If no, describe and justify an alternative procedure (verbal, electronic etc.) in the space below.*

*Guidance on how to draft Participant Information sheet and Consent form can be found on PS6001 Moodle space and in the Handbook.*

N/A

**Question 14: What will participants be told about the study? Will any information on procedures or the purpose of study be withheld?**

*Notes: Include an Information Sheet that sets out the purpose of the study and what will be required of the participant as appendices and refer to it as appropriate. If any information is to be withheld, justify this decision. More than one Information Sheet may be necessary.*

N/A

**Question 15: Will personally identifiable information be made available beyond the research team (e.g. report to organisation)?**

*Notes: If so, indicate to whom and describe how confidentiality and anonymity will be maintained at all stages.*

No

**Question 16: What payments, expenses or other benefits and inducements will participants receive?**

*Notes: Give details. If it is monetary say how much, how it will be paid and on what basis is the amount determined. Indicate RPS credits.*

There will be no payment, expenses or other benefits for participants.

**Question 17: At the end of the study, what will participants be told about the investigation?**

*Notes: Give details of debriefings, ways of alleviating any distress that might be caused by the study and ways of dealing with any clinical problem that may arise relating to the focus of the study.*

N/A

**Question 18: What arrangements are there for data security during and after the study?**

*Notes: Digital data stored on a computer requires compliance with the Data Protection Act; indicate if you have discussed this with your supervisor and describe any special circumstances that have been identified from that discussion. Say who will have access to participants' personal data and for how long personal data will be stored or accessed after the study has ended.*

Digital data (transcripts) will be stored on a password protected computer.  
Only the applicant and co-applicant will have access to digital data for the study.  
Upon award of degree, all digital data will be provided to co-applicant and held securely.

**Signatures of the study team (including date)**

*Notes: The primary applicant and all co-applicants must sign and date the form. Scanned or electronic signatures are acceptable.*

Hannah Heath, 31.01.17

Claire Wyatt, 31.01.17

**ETHICS COMMITTEE DATE: 16/2/17**

**CHAIRS COMMENTS:**

☒ Read and address all reviewers comments

Supervisor to check the clips to be used.

**ACCEPTABLE**

☐ Action: You may now commence with data collection subject to approval from any relevant external agencies.

***DATA COLLECTION IS NOT PERMISSABLE UNDER THESE CONDITIONS***

☒ ACCEPTABLE SUBJECT TO SUBMISSION OF AMENDMENT FORM

☒ Acceptable subject to conditions listed by chair. Discuss conditions highlighted with supervisor and submit ethics application amendment form direct to office.

☐ Acceptable subject to conditions listed by chair: Submit ethics application amendment form direct to office.

**ACCEPTABLE SUBJECT TO CONDITIONS LISTED BY CHAIR:**

☐ Action: Resubmit application for full review ensuring you have completed section B

**REVISE AND RESUBMIT:**

☐ Action: Resubmit application for full review ensuring you have completed section B

**SIGNATURE:** ..... *Maia E. Lafferty* .....



## References

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University of  
Chester

**DEPARTMENT OF PSYCHOLOGY  
ETHICS REVIEW FORM**

**A) Applicant and submission details**

Name of applicant: Wyatt

**Project title:** The relationship between compulsive overeating behaviour and self-harm: An analysis of YouTube videos.

**Applicant status:** ☐ UG ☒ PGT ☐ PGR ☐ Staff

**If you are the applicant's supervisor, have you discussed ethical issues with the applicant?**

☐ Yes, the applicant is an UG/PGT student and I wish to send the application for accelerated student review.

☒ Yes, the applicant is a UG/PGT student and I wish to send the application for full review.

☐ Yes, the applicant is a PGR student and I wish to send the application for full review.

☐ No → Comments:

**B) Review of application**

**1. Has the applicant signed and dated the form?**

a) ☒ Yes ☐ No → Return to applicant for signature before continuing with review process.

**2. What is the submission type?**

a) ☒ First submission to this or any other committee

b) ☐ Resubmission of a rejected application by this committee

• Is there a summary of the requirements of the committee? Is the original application attached?: ☐ Yes ☐ No → Return to applicant for full details

c) ☐ Revised submission intended to replace an application approved by this committee

• Is the original application attached?: ☐ Yes ☐ No → Return to applicant for full details

d) ☐ First submission to this committee; has been submitted to another committee.

• Is the original application attached? ☐ Yes ☐ No → Return to applicant for full details

**3. Research Plan and Methodology**

a) Is the study well formulated in terms of drawing on the relevant literature and is it methodologically, analytically and scientifically sound?

☒ Yes ☐ No Comments:

b) Are the timescales provided appropriate?

☒ Yes ☐ No Comments:

c) Are there contingency details?

☒ Yes ☐ No Comments:

d) Is there consideration of how to minimise, manage and monitor issues of distress and harm, however minor?

☒ Yes ☐ No Comments: [Click here to enter text.](#)

e) Are appropriate debrief details provided?

☐ Yes ☐ No Comments: N/A

f) Are appropriate details regarding the use and management of deception provided?

☐ Yes ☐ No ☐ N/A Comments: N/A

**4. Sample size, participants and recruitment**

a) Has the applicant provided appropriate details of the sample and how it will be identified?

X Yes ☐ No Comments:

b) Has the applicant provided appropriate details of where the research will take place, including issues regarding permission and appropriate health and safety information? Is the necessary documentation attached?

X Yes ☐ No Comments:

If the applicant is a taught student and they did not attend the mandatory H&S briefing have they provided appropriate evidence that they have full and satisfactory awareness of the relevant health and safety protocol?

☐ Yes ☐ No X N/A Comments:

c) Has the applicant provided appropriate details and attached the necessary documentation concerning their recruitment procedures? In particular, have they appropriately considered how to minimise, manage and monitor issues of distress and harm?

☐ Yes ☐ No Comments: N/A

Are there appropriate RPS credits? ☐ Yes ☐ No X N/A

d) Has the applicant provided appropriate details and attached the necessary documentation concerning the information made available to participants? In particular, are there appropriate considerations if using internet mediated research?

X Yes ☐ No Comments:

Is there appropriate consideration of how to manage issues of distress and harm?

☐ Yes ☐ No Comments: N/A

Are there appropriate details regarding informed consent?

X Yes ☐ No Comments:

Are there appropriate details regarding anonymity and confidentiality?

X Yes ☐ No Comments:

Are there appropriate details regarding withdrawal procedures?

☐ Yes ☐ No Comments: N/A

e) Are there appropriate details regarding time commitment from participants?

☐ Yes ☐ No Comments: N/A

f) Are there appropriate details regarding compensation arrangements?

☐ Yes ☐ No Comments: N/A

g) If using social media for recruitment have details been provided on

a. Proposed sites and social groups?

☐ Yes ☐ No Comments:

b. Social media messages?

☐ Yes ☐ No Comments:

**5. Data Collection and Analysis**

a) Has the applicant provided full procedural details and attached the necessary documentation concerning data collection procedures?

X Yes ☐ No Comments:

**6. Data Analysis**

a) Has the applicant provided appropriate details concerning data analysis?

X Yes ☐ No Comments:

**7. Data protection and Storage**

a) Has the applicant provided appropriate details concerning data protection and storage? Have security issues been properly considered?

X Yes ☐ No Comments:

**8. Dissemination**

a) Has the applicant provided appropriate details concerning research dissemination?

X Yes ☐ No Comments:

Are there appropriate details regarding how privacy and confidentiality will be maintained during dissemination?

X Yes ☐ No Comments:

Are there appropriate details regarding any specific considerations about sharing the research?

☐ Yes ☐ No Comments:

General comments: A good application, and a straight-forward study. The applicant has considered the specific ethical issues relevant to using online YouTube videos.

**Review status**

☐ Chair's action

☐ Staff/PGR for full review

X UG/PGT for full review

☐ Work with external agencies

☐ Work with vulnerable participants

☐ Other issues/concerns

**NAME:** Hannah Heath

X Supervisor ☐ Supervisor/Reviewer 1 ☐ Reviewer 1 ☐ Reviewer 2

**DATE:** 13.02.2017



University of  
Chester

DEPARTMENT OF PSYCHOLOGY  
ETHICS REVIEW FORM

A) Applicant and submission details

Name of applicant: Claire Wyatt

Project title: The relationship between compulsive overeating and self-harm: an analysis of youtube videos

Applicant status: ☐ UG ☒ PGT ☐ PGR ☐ Staff

If you are the applicant's supervisor, have you discussed ethical issues with the applicant?

☐ Yes, the applicant is an UG/PGT student and I wish to send the application for accelerated student review.

☐ Yes, the applicant is a UG/PGT student and I wish to send the application for full review.

☐ Yes, the applicant is a PGR student and I wish to send the application for full review.

☐ No → Comments:

B) Review of application

1. Has the applicant signed and dated the form?

a) ☒ Yes ☐ No → Return to applicant for signature before continuing with review process.

2. What is the submission type?

a) ☒ First submission to this or any other committee

b) ☐ Resubmission of a rejected application by this committee

• Is there a summary of the requirements of the committee? Is the original application attached?: ☐ Yes ☐ No → Return to applicant for full details

c) ☐ Revised submission intended to replace an application approved by this committee

• Is the original application attached?: ☐ Yes ☐ No → Return to applicant for full details

d) ☐ First submission to this committee; has been submitted to another committee.

• Is the original application attached? ☐ Yes ☐ No → Return to applicant for full details

3. Research Plan and Methodology

a) Is the study well formulated in terms of drawing on the relevant literature and is it methodologically, analytically and scientifically sound?

☒ Yes ☐ No Comments:

b) Are the timescales provided appropriate?

☒ Yes ☐ No Comments:

c) Are there contingency details?

☒ Yes ☐ No Comments:

d) Is there consideration of how to minimise, manage and monitor issues of distress and harm, however minor?

☒ Yes ☐ No      Comments: Study utilizes existing public domain web content. Potential identification of sample through quotation content has been factored in and appropriate safeguard methods are clearly stated.

e) Are appropriate debrief details provided?

☒ Yes ☐ No      Comments:

f) Are appropriate details regarding the use and management of deception provided?

☒ Yes ☐ No ☐ N/A      Comments:

#### 4. Sample size, participants and recruitment

a) Has the applicant provided appropriate details of the sample and how it will be identified?

☒ Yes ☐ No      Comments:

b) Has the applicant provided appropriate details of where the research will take place, including issues regarding permission and appropriate health and safety information? Is the necessary documentation attached?

☒ Yes ☐ No      Comments:

If the applicant is a taught student and they did not attend the mandatory H&S briefing have they provided appropriate evidence that they have full and satisfactory awareness of the relevant health and safety protocol?

☒ Yes ☐ No ☐ N/A      Comments:

c) Has the applicant provided appropriate details and attached the necessary documentation concerning their recruitment procedures? In particular, have they appropriately considered how to minimise, manage and monitor issues of distress and harm?

☐ Yes ☐ No      Comments: No active recruitment of new participant. Use of existing data.

Are there appropriate RPS credits?      ☐ Yes ☐ No ☒ N/A

d) Has the applicant provided appropriate details and attached the necessary documentation concerning the information made available to participants? In particular, are there appropriate considerations if using internet mediated research?

☒ Yes ☐ No      Comments: Not required for such a study design

Is there appropriate consideration of how to manage issues of distress and harm?

☐ Yes ☐ No      Comments:

Are there appropriate details regarding informed consent?

☐ Yes ☐ No      Comments:

Are there appropriate details regarding anonymity and confidentiality?

☐ Yes ☐ No      Comments:

Are there appropriate details regarding withdrawal procedures?

☐ Yes ☐ No      Comments:

e) Are there appropriate details regarding time commitment from participants?

☐ Yes ☐ No      Comments: not required

f) Are there appropriate details regarding compensation arrangements?

☐ Yes ☐ No      Comments: not required



University of  
Chester

**DEPARTMENT OF PSYCHOLOGY  
ETHICS REVIEW FORM**

**A) Applicant and submission details**

Name of applicant: Claire Wyatt

Project title: The relationship between compulsive overeating behaviour and self-harm: An analysis of YouTube videos.

Applicant status: ☐ UG ☒ PGT ☐ PGR ☐ Staff

If you are the applicant's supervisor, have you discussed ethical issues with the applicant?

☐ Yes, the applicant is an UG/PGT student and I wish to send the application for accelerated student review.

☐ Yes, the applicant is a UG/PGT student and I wish to send the application for full review.

☐ Yes, the applicant is a PGR student and I wish to send the application for full review.

☐ No → Comments:

**B) Review of application**

**1. Has the applicant signed and dated the form?**

a) ☒ Yes ☐ No → Return to applicant for signature before continuing with review process.

**2. What is the submission type?**

a) ☒ First submission to this or any other committee

b) ☐ Resubmission of a rejected application by this committee

• Is there a summary of the requirements of the committee? Is the original application attached?: ☐ Yes ☐ No → Return to applicant for full details

c) ☐ Revised submission intended to replace an application approved by this committee

• Is the original application attached?: ☐ Yes ☐ No → Return to applicant for full details

d) ☐ First submission to this committee; has been submitted to another committee.

• Is the original application attached? ☐ Yes ☐ No → Return to applicant for full details

**3. Research Plan and Methodology**

a) Is the study well formulated in terms of drawing on the relevant literature and is it methodologically, analytically and scientifically sound?

☒ Yes ☐ No Comments:

b) Are the timescales provided appropriate?

☒ Yes ☐ No Comments:

c) Are there contingency details?

☒ Yes ☐ No Comments:

d) Is there consideration of how to minimise, manage and monitor issues of distress and harm, however minor?



☒ Yes ☐ No

Comments: *Content analysis of existing clips.*

e) Are appropriate debrief details provided?

☐ Yes ☐ No

Comments: NA – See above

f) Are appropriate details regarding the use and management of deception provided?

☐ Yes ☐ No ☐ N/A

Comments: Ditto

**4. Sample size, participants and recruitment**

a) Has the applicant provided appropriate details of the sample and how it will be identified?

☒ Yes ☐ No Comments:

b) Has the applicant provided appropriate details of where the research will take place, including issues regarding permission and appropriate health and safety information? Is the necessary documentation attached?

☒ Yes ☐ No Comments:

If the applicant is a taught student and they did not attend the mandatory H&S briefing have they provided appropriate evidence that they have full and satisfactory awareness of the relevant health and safety protocol?

☐ Yes ☐ No ☒ N/A Comments:

c) Has the applicant provided appropriate details and attached the necessary documentation concerning their recruitment procedures? In particular, have they appropriately considered how to minimise, manage and monitor issues of distress and harm?

☒ Yes ☐ No

Comments:

Are there appropriate RPS credits? ☐ Yes ☐ No ☒ N/A

d) Has the applicant provided appropriate details and attached the necessary documentation concerning the information made available to participants? In particular, are there appropriate considerations if using internet mediated research?

☒ Yes ☐ No

Comments:

Is there appropriate consideration of how to manage issues of distress and harm?

☒ Yes ☐ No

Comments:

Are there appropriate details regarding informed consent?

☒ Yes ☐ No

Comments:

Are there appropriate details regarding anonymity and confidentiality?

☒ Yes ☐ No

Comments:

Are there appropriate details regarding withdrawal procedures?

☒ Yes ☐ No

Comments:

e) Are there appropriate details regarding time commitment from participants?

☒ Yes ☐ No

Comments:

f) Are there appropriate details regarding compensation arrangements?

☒ Yes ☐ No

Comments:



g) If using social media for recruitment have details been provided on

a. Proposed sites and social groups?

x Yes ☐ No Comments:

b. Social media messages?

x Yes ☐ No Comments:

**5. Data Collection and Analysis**

a) Has the applicant provided full procedural details and attached the necessary documentation concerning data collection procedures?

x Yes ☐ No Comments:

**6. Data Analysis**

a) Has the applicant provided appropriate details concerning data analysis?

x Yes ☐ No Comments:

**7. Data protection and Storage**

a) Has the applicant provided appropriate details concerning data protection and storage? Have security issues been properly considered?

x Yes ☐ No Comments:

**8. Dissemination**

a) Has the applicant provided appropriate details concerning research dissemination?

x Yes ☐ No Comments:

Are there appropriate details regarding how privacy and confidentiality will be maintained during dissemination?

x Yes ☐ No Comments:

Are there appropriate details regarding any specific considerations about sharing the research?

x Yes ☐ No Comments:

General comments: I think all ethical issues have been addressed, and the supervisor (Hannah Heath) has previously conducted a similar study. Hence, I support this application.

**Review status**

☐ Chair's action

☐ Staff/PGR for full review

☐ Work with external agencies

☐ Other issues/concerns

☐ UG/PGT for full review

☐ Work with vulnerable participants

**NAME:** Mike Boulton

☐ Supervisor ☐ Supervisor/Reviewer 1 ☐ Reviewer 1 ☒ Reviewer 2

**DATE:** 13/2/17

g) If using social media for recruitment have details been provided on

a. Proposed sites and social groups?

☒ Yes ☐ No Comments:

b. Social media messages?

☐ Yes ☐ No Comments: not required

**5. Data Collection and Analysis**

a) Has the applicant provided full procedural details and attached the necessary documentation concerning data collection procedures?

☒ Yes ☐ No Comments:

**6. Data Analysis**

a) Has the applicant provided appropriate details concerning data analysis?

☒ Yes ☐ No Comments:

**7. Data protection and Storage**

a) Has the applicant provided appropriate details concerning data protection and storage? Have security issues been properly considered?

☒ Yes ☐ No Comments:

**8. Dissemination**

a) Has the applicant provided appropriate details concerning research dissemination?

☐ Yes ☐ No Comments:

Are there appropriate details regarding how privacy and confidentiality will be maintained during dissemination?

☐ Yes ☐ No Comments:

Are there appropriate details regarding any specific considerations about sharing the research?

☐ Yes ☐ No Comments:

General comments: Nice project. I have some minor concern regarding impact of video content on the researcher. However, the supervisor is experienced in this field and will be able to provide appropriate guidance to the student.

**Review status**

☐ Chair's action

☐ Staff/PGR for full review

☐ Work with external agencies

☐ Other issues/concerns

☐ UG/PGT for full review

☐ Work with vulnerable participants

**NAME:** Dr Kevin Hochard

☐ Supervisor ☐ Supervisor/Reviewer 1 ☒ Reviewer 1 ☐ Reviewer 2

**DATE:** 15-02-2017

**APPENDIX B**  
**ETHICS AMENDMENT FORM**







**FIRST STAGE OF BRAUN & CLARKE'S (2006) SIX STAGES OF ANALYSIS**

**TRANSCRIPTION WITH LINE NUMBERS**

107

## APPENDIX D

### SECOND STAGE OF BRAUN & CLARKE'S (2006) SIX STAGES OF ANALYSIS

#### CODING THE TRANSCRIPTIONS

1 **Compulsive Eating YouTube Video - CE001**

2 There is a story of a Navajo grandfather who told his grandson(.) "Two wolves live inside of me(.) One is

3 full of greed and laziness(.) jealousy and anger and regret(.) The other is full of joy(.) and kindness and

4 love for the world(.) Always(.) these wolves are fighting inside of me(.)" "But grandfather"(.) the boy

5 said(.) "which one will win?" The grandfather answered(.) "The one that I feed(.)"

6 I think of all the addictions that are out there(.) and eating addiction is one of the hardest to overcome

7 because it's necessary to live(.) It's hard for somebody who had trouble with it to differentiate what you

8 needed to do versus what you wanted to do(.) Food became a real powerful thing for me(.) it's me

9 standing here in the kitchen 2:30 in the morning and uh(.) hah(.) I'm not feeling very good about

10 myself(.) Had a really rough day at work(.) and not able to sleep today and this is what I'm staring at(.)

11 I'm trying really hard not to go in there(.) Sometimes the sickness just really(.) just really controls me(.)

12 Where most of this started(.) I was probably I would say around three or four years old(.) You know my

13 mother did some inappropriate things with me when I was four(.) When she came home late at night I'd

14 be in my room and I'd hear and I'm just(.) you know(.) I'd want her to just come and see me(.) Most of

15 the time she didn't wanna deal with it so(.) There's a pretty wide gap under my door and she used to

16 just shove sandwiches under the door(.) Instead of giving me a hug(.) you know(.) I got a sandwich so(.)

17 To this day sandwiches are like one of my biggest comforts(.) If they serve bread with dinner and I'm

18 having chicken Parmesan(.) I'm gonna put it on the bread and make a sandwich out of it(.)

19 I can remember times as a kid(.) half hour before my mother was making dinner(.) I would sneak a

20 couple of peanut butter and jelly sandwiches down to the garage and then come up and eat dinner(.)

21 would just sit on these steps in the garage here(.) door would be closed(.) and then I would sneak back

22 out(.) Because of the abandonment(.) alls I wanted was acceptance(.) I was about third grade and this

23 one kid said(.) "I can eat more pizza than you"(.) so all the kids in my class divided up their two slices of

24 pizza between us(.) and I went through it and I heard people cheering(.) I think it was more laughter for

25 them but acceptance for me(.)

26 Foods not the answer(.) food is a necessity of life(.) it's not gonna solve your problem(.) I got a page

27 from home and then I got a 911 page(.) My dad answers the phone and he says my brother Paul had

28 died(.) He was 32 years old(.) And every time I talk about this it drives me crazy(.) That sent me out of

29 control that one(.) It took me probably well over two hours to get here but not before I stopped at the

30 fast food restaurant(.) So I looked at the receipt(.) I didn't even know what I had(.) Three Big Macs(.) two

31 large fries(.) a couple of cheeseburgers(.) I think I had a 20-piece nugget(.) And that was less than a mile

32 from here and I ate it before I got here(.)

33 Sometimes it doesn't happen all at once(.) sometimes it's a period of two hours but it's just constant(.)

34 you know(.) it's more of grazing they would call it(.) Most of the times where I was in that kinda zone(.) it

35 was more euphoric for me(.) there was no rational thought(.) it's almost like a drug addict getting that

36 first hit or first high(.) Once I was done I'd be like(.) "Ugh(.) I'm such an idiot(.) why did I do that?" Start

37 putting myself down and then I get a voice(.) it would start talking to you(.) And then it got through a

38 point where like you'd do it again because you felt guilty for doing it the first time so you did it again(.)

39 There'd be times where I'd be in the middle of a good run with getting healthy(.) and exercising(.) and I

40 would tell my wife like I was trying to resist it but it was almost like it was just grabbing my shirt and

**Handwritten Annotations:**

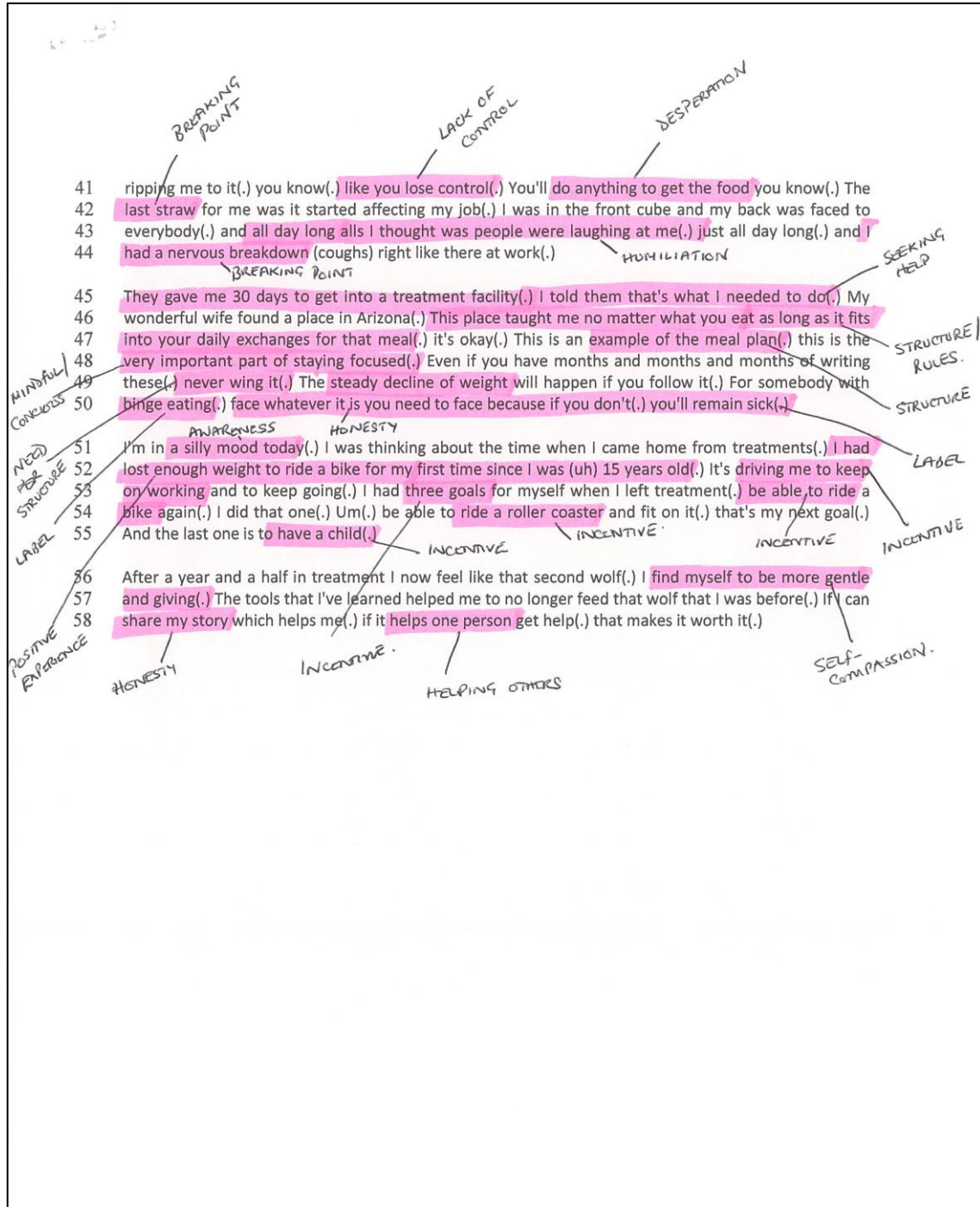
- INNER CONFLICT (lines 1-5)
- OVERWHELMING (lines 6-11)
- NEEDING ACCEPTANCE (lines 12-18)
- EARLY MEMORY (lines 12-18)
- DECEPTION (lines 19-25)
- EARLY MEMORY (lines 19-25)
- NEED ACCEPTANCE (lines 19-25)
- SEEKING ANSWER TO A PROBLEM (lines 26-32)
- UNCONSCIOUS MINDLESS (lines 26-32)
- EUPHORIA (lines 33-38)
- IRRATIONAL BEHAVIOUR (lines 33-38)
- SELF-DEPRECATION (lines 33-38)
- WILL-POWER (lines 39-40)
- TEMPORARY STATE (lines 39-40)
- GUILT + REMORSE (lines 39-40)
- START + END INDICATION (lines 39-40)
- ABANDONMENT (CHAVE) (lines 19-25)
- SHOCK + GRIEF (lines 26-32)
- LACK OF CONTROL (lines 26-32)
- CONSTANT BUT VARYING IN SERenity (lines 33-38)



## APPENDIX D

### SECOND STAGE OF BRAUN & CLARKE'S (2006) SIX STAGES OF ANALYSIS

#### CODING THE TRANSCRIPTIONS



## APPENDIX E

### THIRD STAGE OF BRAUN & CLARKE'S (2006) SIX STAGES OF ANALYSIS

#### SEARCH & CAPTURE OF EMERGING THEMES

Ref	Second stage - Coding	Ref	Third stage - Emerging Themes
CE1/22	Abandonment		<b>ACCEPTANCE</b>
SH3/61-64	Abandonment	SH3/27	Acceptable
CE10/24/26	Abnormal behaviour	CE3/19	
CE4/20	Abnormal eating	CE7/81	
CE1/13	Abuse	CE10/125	
SH3/27	Acceptable	SH4/86	
CE3/19	Acceptance	SH4/182	
CE7/81	Acceptance	SH4/209	
CE10/125	Acceptance	SH5/54	
SH4/86	Acceptance	SH5/77	
SH4/182	Acceptance	SH5/86	
SH4/209	Acceptance	SH5/133	
SH5/54	Acceptance	SH6/38	
SH5/77	Acceptance	SH6/61	
SH5/86	Acceptance	SH6/62	
SH5/133	Acceptance	SH7/54	
SH6/38	Acceptance	SH7/71	
SH6/61	Acceptance	SH7/80	
SH6/62	Acceptance	SH7/67	
SH7/54	Acceptance	SH8/36	
SH7/71	Acceptance	SH8/51	
SH7/80	Acceptance	SH8/40/41	
SH7/67	Acceptance	SH8/110	
SH8/36	Acceptance	SH8/128	
SH8/51	Acceptance	SH10/28	
SH8/40/41	Acceptance	SH10/57	
SH8/110	Acceptance	SH4/135	
SH8/128	Acceptance	SH6/38	
SH10/28	Acceptance	SH4/219-220	
SH10/57	Acceptance	SH5/54	Acknowledgement
SH4/135	Acceptance of behaviour	SH4/137	
SH6/38	Accepted	SH5/44	Acknowledgement of damage to self
CE10/46	Accomplishment	SH4/136	
SH1/7	Accomplishment	SH9/23	
SH2/47	Accomplishment	SH10/12	Diminished
SH3/88	Accomplishment	SH10/56	
SH3/105	Accomplishment	SH5/137	Letting go of internal negativity
SH4/181	Accomplishment	SH5/142	Long process
SH5/67/68	Accomplishment	SH2/16	
SH5/110	Accomplishment	SH3/85	
SH8/65	Accomplishment	SH3/105	
SH8/94/95	Accomplishment	SH7/61	Love
SH10/43	Accomplishment	SH8/78	
CE5/41-42	Accountability	SH4/53	Love shown as anger
SH1/7	Achievement	SH9/23	Misunderstood
SH2/47	Achievement	SH5/14	Misunderstood topic
SH4/219-220	Acknowledgement	CE1/22	
SH5/54	Acknowledgement	CE1/25	Need for acceptance
SH4/137	Acknowledgement of damage to self	SH9/25	
SH5/44	Acknowledgement of damage to self	SH4/134	
CE9/10	Acting on thought	SH10/15	Need for attention
SH3/96	Action	SH4/30	Need for perfection
SH3/90	Action	CE4/33	Need to be accepted
SH4/165	Action	CE4/2	New to youtube
SH5/105	Action	SH3/17	Not trivialising
SH5/121	Action	SH1/18	Open to change
SH6/50	Active	CE3/39	
SH8/48/49	Affirmation	CE3/42	Openness to learning
SH6/5	Age	SH3/4	
SH6/5	Age	SH3/54	Pleasing others
SH4/100	Aggression	SH3/79	
SH9/81	Alive	SH4/126	
SH9/86/89/93	Alive	SH6/29	
CE1/22	Alone	SH2/10	
CE4/12	Alone	SH2/16	
CE4/12	Alone	SH2/11	
CE7/30	Alone	SH3/61-64	Rejection
CE9/14	Alone	SH4/117	
CE9/29	Alone	SH4/120	
SH2/16	Alone	SH5/100	
SH3/97	Alone	SH5/118	
SH4/48	Alone	CE8/277	
SH6/4	Alone	CE9/81	
SH6/24/16	Alone	CE9/98	
SH9/90/61	Alone	CE9/131	
CE3/38	Alternative action	CE10/53	
SH3/32/33/36	Alternative behaviour	CE10/138/139	Self-acceptance
CE10/87/89	Alternative coping mechanisms not internalised	SH2/49	
CE10/87	Alternative coping strategy	SH3/92	
SH1/16	Alternative coping strategy	SH3/91	
SH4/89	Alternative coping strategy	SH6/59	
SH8/39	Alternative coping strategy	SH7/48	
SH8/38/39	Alternative coping strategy	SH7/72	
SH3/46	Anger	CE10/90	
SH4/46	Anger	SH1/27	
SH4/44	Anger	SH2/12	Self-blame

## APPENDIX F

### FOURTH STAGE OF BRAUN & CLARKE'S (2006) SIX STAGES OF ANALYSIS

#### UNDERSTANDING THE RELATIONSHIPS BETWEEN THE THEMES

